



OHSUHealth

OHSU HEALTH IDS

Compliance Plan

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Fraud, Waste and Abuse Handbook

2025

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OHSU HEALTH IDS Fraud, Waste and Abuse Handbook

Fraud, Waste and Abuse Handbook Purpose

OHSU Health IDS has adopted this Fraud, Waste and Abuse (FWA) Handbook to articulate OHSU Health IDSs' 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. The executive leadership and the Board of Directors are committed to, the promotion of an organizational culture that encourages ethical conduct and places the highest value on integrity in the achievement of its mission and staying true to our core values of quality, transparency, service, excellence and diversity.

OHSU Health IDS is committed to conducting business in a lawful and ethical manner which includes prevention, detection and correction of fraud, waste and abuse. The FWA Handbook is a framework and the foundation to articulate our commitment to comply with all Federal and State laws and regulations and our internal policies and procedures. The FWA Handbook contains all OHSU Health IDS fraud, waste and abuse policies and procedures implemented.

Compliance is everyone's responsibility. Please familiarize yourself with this handbook to ensure we maintain our high standards of compliance and ethical principles. We thank you for your commitment and continued support in serving our members.

Who does the FWA Handbook apply to?

OHSU Health IDS's FWA Handbook applies to all IDS employees, Officers, Board of Directors and all members of the various Committees who participate in any aspect of the IDS business. In addition, this FWA Handbook applies to our Subcontractors, Delegates/Delegated Entities, vendors and Participating Providers, as required, and in accordance with applicable Attachments.

What are my expectations?

You are required to read and be familiar with the FWA Handbook at the time of hire, appointment or contracting, and annually thereafter. You have an obligation to learn to recognize potential non-compliant, fraud, waste, or abuse (FWA) issues that may arise during your work, report them to the appropriate channel, and assist in remediating them. You should strive to improve processes to minimize compliance and FWA risks to OHSU Health IDS, our members, and our Regulators. Ultimately, you are a champion and an advocate for compliance, and you are a part of our culture of compliance.

Adoption and Dissemination

Adoption

The FWA Handbook, the Code of Conduct, and supporting compliance policies and procedures will be reviewed and updated at least annually. The OHSU Health IDS Regulatory Compliance Committee will review and approve the documents. Additionally, if required by a Regulator, these documents will be reviewed and/or approved by that Regulator prior to formal adoption and publication for the applicable line of business. If substantive changes are required more frequently than annually, these documents will be subject to the same review, approval, and adoption process that is required during the annual review.

Dissemination

The FWA Handbook and Code of Conduct are disseminated in accordance with the following schedule:

OHSU Health IDS Workforce:

- At time of hire: the department manager shall disseminate the FWA Handbook including the Code of Conduct, to new employees within 90 days of hire.
- Annually: The Compliance Department shall disseminate the FWA Handbook, and the Code of Conduct, to the IDS workforce annually thereafter, and when there are substantive updates.

Board of Directors:

- At time of appointment: The Corporate Compliance Officer will disseminate the FWA Handbook and Code of Conduct to new members of the Board of Directors upon their appointment or prior to attending their first meeting.
- Annually: The Corporate Compliance Officer will disseminate the FWA Handbook and Code of Conduct to members of the Board of Directors annually thereafter, and when there are substantive updates.

OHSU Health IDS FWA Handbook at a Glance

The FWA Handbook and the supporting policies, procedures and guidance describe and implement the compliance standards by which our State and Federal programs are governed. All the referenced documents as a whole implement the FWA Handbook. The documents that make up the FWA Handbook address each element in the following attachments. This ensures each requirement is implemented through one or more supporting policy(s) and procedure(s) identified.

This FWA Handbook is applicable to all OHSU Health IDS employees. The Code of Conduct, in combination with this document, and the supporting policies and procedures listed in the tables below make up the FWA Handbook in accordance with requirements set forth in 42 CFR §438.600-438.610, §433.116, §438.214, §438.808, §455.20, §455.104 – 455.106, §1002, and OAR 141-120-1510. This FWA Handbook enables OHSU Health IDS to detect, prevent and correct potential FWA activities that have been engaged in by our employees, Subcontractors, Participating Providers, Members, and/or other third parties.

Definitions

Abuse: Actions that may, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid Program; improper payment; payment for services that fail to meet professionally recognized standards of care; or services that are medically unnecessary.

Auditing: An audit is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws, and regulations) used as base measures.

Credible Allegation of Fraud: A credible allegation of fraud may be an allegation which has been verified by the State or from any source, including but not limited to the following: fraud hotline complaints; claims data mining; patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Delegate/Delegated Entity: A formal process by which the organization gives another entity the authority to perform certain functions on its behalf. Although the organization may delegate the authority to perform a function, it may not delegate responsibility for ensuring that the function is performed appropriately. A delegated entity is the entity or person to which the authority is given by CareOregon to perform certain functions.

DHS/OHA FI: DHS/OHA Fraud Investigation

Downstream Entity: is any party that enters into a written arrangement, acceptable to the Centers for Medicare and Medicaid Services (CMS), with persons or entities involved with the Medicare Advantage (MA) benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization (MAO) or applicant or a Part D plan sponsor or applicant and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative

services. (See, 42 C.F.R. §423.501).

First Tier Entity (FTE): is any party that enters a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program. (See, 42 C.F.R. §423.501).

Fraud: intentional deception or misrepresentation that any individual including employees, Subcontractors, Participating Providers, Members, and/or other third parties 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 employee, Subcontractor, Participating Provider, Member, and/or other third parties.

LEIE: List of Excluded Individuals

MFCU: Medicaid Fraud Control Unit

Monitoring: analysis of various operational processes designed to prevent issues of noncompliance. Regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

OHA: Oregon Health Authority

OIG: Office of Inspector General (OIG)

OPI: Office of Program Integrity

Overpayment: Overpayment means any payment made to a network provider by OHSU Health IDS, to which the network provider is not entitled to under Title XIX of the Social Security Act or any payment to a CCO by a State to which the CCO is not entitled to under Title XIX of the Social Security Act

Participating Provider: means a physician, facility, or other provider of health- related services that holds a contract with OHSU Health IDS.

Regulator: means any entity OHSU Health IDS is governed by including Federal and State agencies. Some examples are CMS, OHA, and state specific Insurance Divisions.

SAM: System for Award Management

Subcontractor: means any individual, entity, facility, or organization, other than a Participating Provider, who has entered into a Subcontract with the Contractor (the CCO) or with any Subcontractor for any portion of the work under the Contract.

Waste: Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Whistleblower: an individual who, without authorization, reveals private or classified information about an organization, usually related to wrongdoing or misconduct

Compliance Program

The OHSU Health IDS has a robust Compliance Program that is overseen by the IDS Board of Directors who is responsible for the reasonable oversight of the Program with respect to its implementation and effectiveness. 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 Program includes a description of the following seven elements of an effective compliance program as they relate to OHSU Health IDS structure:

1. Written Policies, Procedures and Code of Conduct
2. Compliance Officer, Compliance Committee and High-Level Oversight
3. Effective Training and Education
4. Effective Lines of Communication
5. Well-Publicized Disciplinary Standards
6. System for Routine Monitoring, Auditing and Identification of Compliance Risks
7. Procedures and System for Prompt Response to Suspected Violations

Element 1: Written Policies, Procedures and Code of Conduct

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, OAR 410-120-1510, OAR 410-141-3520 and OAR 410-141-3625 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.

The IDS written policies, procedures and a Code of Conduct:

- Articulates the IDSs' commitment to comply with all applicable federal and state statutory and regulations.

- Describe the expectations of staff/subcontractors/providers and other agents as outlined in the Code of Conduct.
- Describe the structure and operation of the compliance program.
- Provide guidance to staff on how to handle suspected, detected or reported compliance issues.
- Staff/subcontractor/provider compliance and FWA training requirements.
- The operation of the anonymous compliance hotline and additional communication mechanisms to inform IDS designated Compliance Officer of suspected, detected or reported compliance or FWA issues.
- Identify how to communicate compliance issues to the Compliance Officer.
- Describe how reported compliance issues are investigated and resolved by appropriate personnel.
- Describe IDS policy of non-intimidation and non-retaliation for good faith participation in the compliance program and,
- The processes used to evaluate compliance activities delegated to partners.

Policies and procedures are updated to include any changes in applicable laws, requirements or regulations as needed.

Element 2: Compliance Officer, Compliance Committee and High-Level Oversight

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

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.

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.

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.

Element 3: Effective Training and Education

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.

Element 4: Effective Lines of Communication

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.

Element 5: 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.

Element 6: System for Routine Monitoring, Auditing and Identification of Compliance Risks

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.

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.

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.

Element 7: Procedures and System for Prompt Response to Suspected Violations

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.

Fraud, Waste & Abuse

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 Fraud, Waste and Abuse Prevention Plan, Fraud, Waste and Abuse Handbook and all related activities.

How to Report FWA Concerns

OHSU Health IDS takes fraud, waste and abuse matters very seriously, and we comply with all applicable laws, including the State and Federal False Claims Act. If you identify suspicious activity,

or if you want to report a case of fraud, waste, abuse, or any other compliance concern you can do so using any of the following options below. Anyone, including Employees, member of the Board of Directors, subcontractor, business associate, FDR, participating providers or members can report issues or concerns of potential compliance, privacy, or FWA. OHSU Health IDS emphasizes the obligation to report compliance and FWA issues by bolstering a safe environment for reporters and whistleblowers to report without fear of retaliation as OHSU Health IDS strictly prohibits anyone from retaliating against any person who reports matters in good faith.

Anonymous Reporting available 24 hours, 7 days a week: 1-877-733-8313

Website: www.ohsu.edu/hotline.

Compliance Officer can be reached at 503-416-4700.

Email the Compliance Officer, Nick Gross at nick.gross@modahealth.com

Report to your supervisor or manager.

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 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. 410-120-1396 describes the right to and the process for auditing provider payments.
 3. OAR 410-120-1397 describes the basis for denying claims payment and the process for recouping payments or obtaining refunds of payments to Providers.
 4. 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.
 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.

Policies and Procedures of the FWA Handbook

OHSU Health IDS, LLC		Policy & Procedure			
Company:	OHSU Health IDS, LLC	Committee Name:	IDS Regulatory Compliance		
Subject:	OHSU Health IDS Code of Conduct and Conflict of Interest				
P&P Original Effective Date:	1/1/2020	P&P Origination Date:	1/1/2020	P&P Published Date:	1/1/2020
P&P Previous Revision Effective Date:	3/13/2023	P&P Revision Published Date:	9/8/2025		
Reference Number:	COMP-101	Next Review Date:	9/2026		
Product (check all boxes applicable to this policy) <input type="checkbox"/> Dental <input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Pharmacy <input type="checkbox"/> Behavioral Health					

I. Policy Statement and Purpose

- A. This Code of Conduct and Conflict of Interest Policy (the “Code”) has been adopted by the OHSU Health IDS and the Board of Directors in order to set forth the general principles and standards to which our Board of Directors as well as any Covered Person, are expected to adhere. All Covered Persons are expected to perform their responsibilities in compliance with the Code, applicable laws, company policies and contractual requirements. In addition, if at any time you believe that a legal or ethical violation has occurred, we ask that you report it to OHSU Health IDS’ Compliance Officer or the Compliance hotline.

- B. Honesty, integrity and transparency are core values for OHSU Health IDS. Covered Persons are expected to lead with sound, ethical decisions as they interact with members, regulators, providers, suppliers, colleagues and customers at large. As part of our ethics and integrity focus, OHSU Health IDS has adopted this Code of Conduct that describes ethical and legal responsibilities of all Covered Persons acting on behalf of OHSU Health IDS. The Code is the framework for OHSU Health IDS Corporate Compliance Program and is developed to protect the interests of OHSU Health IDS in connection with any transaction or arrangement that might benefit the private interests of any Covered Person, as identified below. The Code provides the framework and a systematic mechanism for disclosing and evaluating potential and actual conflicts; and provides procedures for the Board of Directors in considering any transaction or arrangement where a conflict may exist.

- C. The Code of Conduct applies to all members of the workforce, and the members of Board. OHSU Health IDS will provide a work environment that supports honesty, integrity, and respect in the treatment of workers related to the below areas.
 - 1. **Ethical Conduct and Compliance:** In the performance of duties, staff members will set an example of ethical behavior, and comply with all laws and regulations that govern the business. Staff must never sacrifice ethical and compliant behavior in the pursuit of business objectives.
 - 2. **Accuracy, Retention and Disposal of Documents and Records:** Employees responsible for the integrity and accuracy of any organizational documents or records that are written or modified. Falsifying or altering documents or records is absolutely prohibited. This includes improperly back-dating documents. Employees are also expected to become familiar with and comply with policies and procedures that address the retention and disposal of the

- organization's documents and records.
3. **Business and Financial Reporting and Records:** In order to provide accurate and reliable financial records, all financial transactions shall be recorded and according to generally accepted accounting principles (GAAP) and OHSU Health IDS policies and procedures. Internal controls have been implemented to provide reasonable assurance that management has authorized a transaction and that it has been properly recorded.
 4. **Confidentiality of Business and Member Information:** Employees have an ethical duty to protect the confidentiality of information about trade secrets, confidential business plans, and proprietary business information. When in doubt about whether or not information may be shared, it is the responsibility of the employee to contact the Chief Executive Officer (CEO) or Chief Compliance Officer. Employees are also expected to comply with policies and procedures regarding the confidentiality of member health information. Identifiable member information shall not be shared with others who do not have a legitimate need to know in order to perform their specific job or to carry on business. The use of member, worker or any individual's or entity's information for personal benefit is absolutely prohibited.
 5. **Treatment of others:** OHSU Health IDS prohibits all forms of discrimination, including harassment of any kind. Members of the staff shall be treated with dignity and respect, regardless of their age, gender, gender identity, race, ethnicity, national origin, religion, sexual orientation, disability, socioeconomic status, or any other basis protected by applicable law.
 6. **Conflict of Interest:** A conflict of interest occurs when personal interests could interfere with their ability to make a fair and objective decision on behalf of OHSU Health IDS, or create opportunities for fraud or self-enrichment. Employees should avoid relationships and activities that create, or even appear to create, a conflict of interest. At times, an employee may be faced with situations in which business actions taken on behalf of OHSU Health IDS may conflict with the employee's own personal interests. OHSU Health IDS property, information or business opportunities may not be used for personal gain. If one is unsure whether a conflict of interest exists, they should talk with the person to whom they report or the Chief Compliance Officer.
 7. **Gifts and Gratuities:** OHSU Health IDS employees will not accept items from vendors in excess of \$50.00 (fifty dollars) per year, per individual. For perishable or consumable gifts, the aggregate value of the gift may not exceed \$1,000.00 (one thousand dollars). Regardless of value, no more than two perishable or consumable gifts may be accepted per vendor per year. For gifts that are not perishable or consumable, the aggregate value of the gift may not exceed \$250.00 (two-hundred and fifty dollars). All gifts, gratuities, or other compensation from a vendor must be disclosed to the employee's supervisor or manager, or to the CEO for members of OHSU Health IDS board of directors.
 8. **Personal Use of OHSU Health IDS Resources:** Anything beyond incidental personal use of OHSU Health IDS materials, supplies or equipment is prohibited without prior approval from executive leadership. Property must not be removed from a facility owned or managed by OHSU Health IDS without proper authorization. If removed, property must be returned to the facility as soon as practicable, after it is no longer needed for authorized purposes. 411.690(2)).

D. Framework of Compliance

1. Antitrust laws make sure competition between companies is fair. These laws also protect the public against business competitors who band together or "collude" to unfairly set prices. You could be breaking these laws if you do things as simple as discuss competitors pricing, terms and conditions of sales; or dealings with customers, suppliers or other competitors. Our competitors include managed care organizations, health care delivery companies and insurance companies that operate in our markets.
2. To the extent that, OHSU Health IDS is subject to the Federal Procurement Integrity Act

when bidding on Federal contracts. All Covered Persons must comply with these federal statutes: 41 USC §423 and 18 USC §§207 and 208. In general, these laws prohibit certain business conduct for companies seeking to obtain work from the federal government. More specifically, these laws place restrictions or prohibitions on staff and contractors from engaging in the following activities:

- a. Offering or discussing employment or business opportunities at OHSU Health IDS with current or former agency procurement officials
 - b. Offering or giving gratuities or anything of value to any agency procurement official
 - c. Seeking or obtaining any confidential information about the selection criteria before the contract is awarded
3. Resources, seeking guidance and reporting violations. Each Covered Person should feel free and comfortable to contact OHSU Health IDS Compliance Officer at nick.gross@modahealth.com, careyba@ohsu.edu or the Compliance Hotline at 1-877-733-8313 (toll free) or www.ohsu.edu/hotline.
 4. If OHSU Health IDS initiates an investigation to determine whether there has been illegal or unethical conduct, OHSU Health IDS expects Covered Persons to cooperate with the investigation and disclose all information and records that are relevant to the investigation. Failure to cooperate with an internal investigation is a violation of this Code of Conduct and can lead to disciplinary action and/or contract termination.
 5. Once a problem or suspected violation is reported, OHSU Health IDS pledges to quickly investigate and resolve the problem. OHSU Health IDS won't retaliate against any Covered Person for reporting ethics or compliance violations in good faith. As much as possible, OHSU Health IDS takes reasonable precautions to maintain the confidentiality of those who report compliance concerns.
 6. Any retaliation against a Covered Person, who, in good faith, reports a suspected violation of this Code, the law, company policies, or contractual obligations, is not permitted and should be immediately reported to the Compliance Officer. Any Covered Person who makes malicious or purposely false reports also violates this Code of Conduct.
 7. Failure to follow this Code and any other company policies, applicable laws and contractual obligations will compromise OHSU Health IDS integrity and reputation. No Covered Person is ever authorized to commit or direct another person to commit an unethical and illegal act. In addition, no person can use a contractor, agent, consultant, distributor or other third party to perform any act not allowed by law, this Code, OHSU Health IDS policies or any applicable contractual obligation.

E. Conflict of Interest

1. A Covered Person may have a conflict of interest with respect to a transaction or arrangement whenever they, or any of their family members:
 - a. Receives compensation or other funding directly or indirectly from the Corporation and the transaction or arrangement involves such compensation or funding;
 - b. Has or anticipates having a compensation arrangement with any entity or individual that: sells or purchases IDS from OHSU Health IDS; has other transactions or arrangements with OHSU Health IDS; or competes with OHSU Health IDS;
 - c. Has or anticipates having any ownership interest, investment interest, or serves or anticipates serving as a director or officer of, any entity as described in b above;
 - d. Has accepted any gift or other favor where such acceptance might create the appearance of influence on the Covered Person (other than gifts of nominal value (less than \$50.00), which are clearly tokens of respect and friendship unrelated to any particular transaction).
2. There is no conflict of interest if the Covered Person owns securities of a publicly traded company with which OHSU Health IDS has a transaction or arrangement if the securities owned are less than 5% of the outstanding securities of the publicly traded company; and the

fair market value is less than 5% of the Covered Person's annual gross income.

II. Definitions

- A. **Covered Person:** Any director or officer of OHSU Health IDS, a member of any OHSU Health IDS committee, council, workgroup, task force, and employees and independent contractors of OHSU Health IDS.

III. Procedures

A. Code of Conduct and Conflict of Interest Responsibilities of Covered Persons

1. Every Covered Person is expected perform their duties for OHSU Health IDS in good faith and with the degree of care that an ordinarily prudent person would exercise under similar circumstances. This is known as "Duty of Care".
2. Every Covered Person is expected to be loyal to OHSU Health IDS. A Covered Person is not use their position with OHSU Health IDS for personal profit or gain other personal advantage. This is known as "Duty of Loyalty".
3. Every Covered Person must refrain from conducting any transaction or making an arrangement with other organizations that involve a conflict of interest and should avoid both actual conflicts and the appearance of conflicts of interest. Every Covered Person is required to:
 - a. Disclose all actual and potential conflicts; and
 - b. Recuse themselves from voting on any transaction or arrangement in which they have a potential or actual conflict of interest, and, if so requested by the Board's Chair, not be present when any such vote is taken.

B. Disclosure and Evaluation of Conflicts

1. Each Covered Person promptly and fully discloses all material facts of every actual or potential conflict of interest:
 - a. Existing at the time when they become a Covered Person;
 - b. That arises while they are a Covered Person, at the time such actual or potential conflict arises; and
 - c. Annually through the annual Conflict of Interest Questionnaire.
2. The Board Chair discloses to the Board of Directors all conflicts of interest reported to them under this Code. The Board of Directors evaluates the disclosures to determine whether they involve actual conflicts of interest and may attempt to develop alternatives to remove the conflict from the situation.

C. Acting on Conflict of Interest Transactions

1. OHSU Health IDS may enter into a transaction or arrangement in which a Covered Person has a conflict of interest if:
 - a. The Covered Person has disclosed the conflict of interest according to this Code
 - b. A majority of directors who have no interest in the transaction or arrangement approve the transaction or arrangement at a Board meeting after determining, in good faith and after reasonable investigation, that the transaction or arrangement is fair and reasonable to OHSU Health IDS and is in OHSU Health IDS best interest;
 - c. Any Covered Person who has an actual or potential conflict with respect to a transaction or arrangement does not participate in and, if so requested by the OHSU Health IDS Chair, is not present for the vote regarding the transaction or arrangement (however, that Covered Person may appear at a meeting to answer questions concerning the transaction or arrangement); and
 - d. The Board of Directors relies upon appropriate comparability data, such as an independent appraisal or an independent compensation study, in reaching its determination as to the equity and reasonableness of the transaction or arrangement to OHSU Health IDS.

2. It is not a violation of the Code if all the requirements for formal approval, outlined above, are not satisfied, so long as the transaction or arrangement is equitable to OHSU Health IDS.

D. Code of Conduct and Conflict of Interest Records of Proceedings

1. The minutes of the Board of Directors described above shall contain:
 - a. The names of the persons who disclosed an actual or potential conflict of interest or otherwise were found to have a conflict of interest, and the nature of the conflict of interest; and
 - b. The names of the persons who were present for discussions and votes relating to the transaction or arrangement, the content of the discussion, including any alternatives to the proposed transaction or arrangement considered and the appropriate comparability data relied upon, and a record of any votes taken.
2. The minutes are prepared by the next succeeding meeting of the Board of Directors meeting.
3. Disposal or destruction of all records is governed by law and policy. The retention of records will be in accordance with legal and regulatory requirements. Records pertaining to litigation (current/threatened), government investigation or audit shall not be destroyed.
4. Records will be maintained in appropriate format (paper, electronic copies and images) and available within a reasonable timeframe. Records are maintained for a period of ten (10) years.

E. Fraud and Abuse Reporting Obligation and Resources

1. Personal Obligation to Report: Covered persons are responsible to report any activity that appears to violate applicable laws, rules, regulations, or the Code of Conduct. If a concern has been reported and one believes that it has not been resolved, contact the Chief Compliance Officer.
2. Resources for Guidance: OHSU Health IDS encourages discussions regarding concerns with a manager, CEO or President or the Chief Compliance Officer. The Compliance Officer may be reached via the Hotline at 1-877-733-8313 or at www.ohsu.edu/hotline. OHSU Health IDS cannot guarantee that it will keep personal identity confidential, but OHSU Health IDS will maintain confidentiality within the limits of the law and ability to investigate the issues brought to OHSU Health IDS attention. OHSU Health IDS absolutely prohibits, and will not tolerate, retaliatory discipline against a worker who reports concerns using the channels described above. Claims of retaliation will be investigated and, if substantiated, appropriate action will be taken. OHSU Health IDS takes health care fraud and abuse very seriously. It is OHSU Health IDS policy to provide information to all employees, contractors and agents about the federal and state false claims acts, remedies available under these acts and how employees and others can use them, and about whistleblower protections available to anyone who claims a violation of the federal false claims acts. OHSU Health IDS will also advise our employees, contractors, and agents of the steps OHSU Health IDS has put in place to detect health care fraud and abuse. An employee, contractor, temporary worker, or volunteer who provides care or has access to clients, client information, or client funds within or on behalf of any entity or agency licensed, certified, registered, or otherwise regulated by the Department or Authority is subject to a standard criminal history check at hire and monthly sanction check.
3. Procedure for Reporting: If it is believed that OHSU Health IDS may have made a false claim as discussed above, Covered Persons are encouraged to: Report it to the Chief Compliance Officer at (877) 733--8313 or at www.ohsu.edu/hotline for further investigation. It may also be reported directly to the federal Department of Justice; reporting to OHSU Health IDS is not required first.
4. Report any retaliation that may be experienced from OHSU Health IDS to OHSU Health IDS or the federal government of a possible false claims act violation to the Federal Department of Justice.

5. OHSU Health IDS Policies and Procedures for Detecting Fraud and Abuse: Policies and procedures for detecting fraud and abuse are found in the OHSU Health IDS Compliance Plan. More detailed information about the False Claims Act is available from the Chief Compliance Officer.
6. Training Policy: OHSU Health IDS will train all new members of the workforce, contractors, and agents regarding federal and state false claims acts and also provides annual and periodic updates for existing members of our workforce, contractors, and agents. All members of OHSU Health IDS workforce are required to participate in training. All contractors and agents are required to participate in scheduled training, as determined by Chief Compliance Officer.

F. Accounting and Record Keeping

1. Covered Persons must maintain reliable records that facilitate accurate reporting to OHSU Health IDS and governmental agencies and comply with applicable legal requirements.
2. Improper or fraudulent accounting, documentation or financial reporting may be in violation of the law. Adequate documentary evidence must support all cost reports or claims submissions.
3. Every Covered Person is expected to comply with the Health Insurance Portability and Accountability Act (HIPAA) legal requirements regarding Protected Health Information (PHI). PHI includes medical diagnosis and treatments, personal data, billing and contract information. OHSU Health IDS policies regarding handling and use of PHI will be adhered to by all Covered Persons who become our Business Associates pursuant to HIPAA in order to receive or process our Members' PHI. The policies conform to federal and state laws and are designed to safeguard patient privacy.

G. Each Covered Person is responsible to sign a statement acknowledging that they have received a copy of this Code, that they have read and understand its content, and agrees to comply with it. They are also required to complete a Conflict of Interest Questionnaire.

H. If the Board of Directors has reasonable cause to believe that a Covered Person has failed to comply with the Code, the Board may counsel the Covered Person regarding such failure and, if the issue is not resolved to the Board's satisfaction, may consider additional corrective action as appropriate.

IV. Fraud, Waste and Abuse Statutes

A. OHSU Health IDS takes health care fraud and abuse very seriously. It is OHSU Health IDS policy to provide information to all Covered Persons about the federal and state false claims acts, remedies available under these acts and how Covered Persons can use them, and about whistleblower protections available to anyone who claims a violation of the federal false claims acts. OHSU Health IDS also advises Covered Persons of the steps OHSU Health IDS has put in place to detect health care fraud and abuse. The Federal False Claims Act is a federal law that imposes liability on persons and companies who defraud governmental programs. It is the federal government's primary litigation tool in combating fraud against the government. The law includes a qui tam provision that allows people who are not affiliated with the government, called "relators" under the law, to file actions on behalf of the government (informally called "whistleblowing").

1. Persons filing under the Act stand to receive a portion of any recovered damages. This statute allows a civil action to be brought against a health care provider who:
 - a. Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to any federal employee;
 - b. Knowingly makes, uses or causes to be made or used a false record or statement to get a false or fraudulent claim paid; or
 - c. Conspires to defraud the government by getting a false or fraudulent claim allowed or paid (31 USC SEC 3729(a)).
2. **Examples of a False Claim:** Billing for procedures not performed; up-coding health care

services; falsifying information in the medical record.

Remedies: A federal false claims action may be: brought by the U.S. Department of Justice, or brought by an individual as a qui tam action (this means the individual files an action on behalf of the government); punishable by a civil penalty of between \$10,781 and \$21,563 per false claim, plus three times the amount of damages incurred by the government; and subject to a statute of limitations that controls how much time may pass before an action may no longer be brought for violation of the law. Under the False Claims Act, the statute of limitations is six (6) years after the date of violation or three (3) years after the date when material facts are known or should have been known by the government, but no later than ten (10) years after the date on which the violation was committed.

3. **Federal Whistleblower Protections:** Federal Law prohibits an employer from discriminating against an employee who initiated or otherwise assisted in a false claims action. The employee is entitled to all relief necessary to make the employee whole. 31 USC 3730(h).
4. **Oregon Whistleblower Statutes:** Criminal and civil laws that prohibit Medicaid fraud are outlined below. It is a crime if a health care provider knowingly submits, or causes to be submitted, a claim for payment to which the provider is not entitled. ORS 180.755; ORS 411.675; ORS 165.690.692. A healthcare provider is subject to civil damages if it has been previously warned against certain billing practices. ORS 411.690(2)).
5. **Oregon Whistleblower Protections:** Oregon law contains several provisions that prohibit retaliatory action by a healthcare provider against an employee who, in good faith, brings evidence of unlawful practices to the attention of the proper authority. ORS 441.181, ORS 441.057, ORS 659A.233, ORS 659A.203. Further, an employee who believes he or she is the victim of retaliation may file a complaint with the Oregon Bureau of Labor and Industries. (ORS 659A.200 – 659A.233).
6. **Medicaid Waste and Abuse:** In addition to an intolerance of Medicaid fraud, OHSU Health IDS prohibits Medicaid waste and abuse, defined as follows:
 - a. **Waste:** The extravagant, careless, or unnecessary utilization of, or payment for, health care services.
 - b. **Abuse:** An activity or practice undertaken by a member, practitioner, employee, or contractor that is inconsistent with sound fiscal, business or health care practices and results in unnecessary cost to OHSU Health IDS, reimbursement for services that are not medically necessary, or an activity or practice that fails to meet professionally recognized standards for health care.
 - c. **Additional Information:** If you have any questions about this information, contact the Chief Compliance Officer at 503-952-5033 or call the Hotline at (877) 733-8313.
 - d. **Obeying All Laws:** Members of OHSU Health IDS workforce are required to follow all applicable federal, state and local laws. Any member of the OHSU Health IDS workforce who believes themselves to have received instructions otherwise must immediately inform the Chief Compliance Officer or members of the OHSU Health IDS Board of Directors.

B. Oregon State Laws

1. **Wrongful Claims (ORS 411.670 – 411.690)**

Any person who submits a claim or accepts a payment from the Department of Human IDS for IDS that were not provided is liable to refund or credit the amount of such payment, and if found to have violated this prohibition after an administrative hearing pursuant ORS chapter 183, shall be liable for treble the amount of the payment wrongfully received.
2. **Unlawful Trade Practices (ORS 646.605 – 646.656)**

Any person who wrongfully collects or attempts to collect any debt in excess of what is owed, or by unfair means, may be held liable for the debtor's actual damages or \$200, whichever is greater, plus reasonable attorneys' fees. Any person who violates a court injunction or assurance of voluntary compliance under these provisions may be liable to the

- state for up to \$25,000 per violation.
3. Perjury and Falsification (ORS Chapter 162)
A person commits the crimes of perjury (if the falsehood is material) and false swearing by making false sworn statements, and can be convicted of a Class C felony or Class A misdemeanor, respectively, A person commits the crime of unsworn falsification by knowingly making any false written statement to a public servant in connection with an application for any benefit, and can be convicted of a Class B misdemeanor.
 4. Falsification of Business Records (ORS 165.080)
A person commits the crime of falsifying business records if, with intent to defraud, the person makes a false entry in business records, alters, deletes or prevents a true entry, or fails to make a true entry in violation of a known, legal duty, and thereby commits a Class A misdemeanor.
 5. False Claim for Health Care Payment (ORS 165.690 – 165.698)
A person or entity commits the crime of submitting a false claim for health care payment by knowingly making or causing to be made a claim for any health care payment that contains any false statement or false representation of material fact in order to receive the payment. It is also a crime for any person or entity to conceal from or fail to disclose to a health care payor the existence of any information with intent to obtain any health care payment to which the person or entity is not entitled.
 - a. In addition, it is also a crime for any person or entity to obtain or attempt to attain any state-funded medical assistance payment by submitting or causing to be submitted any false claim for payment, or accepting any such payment, for any duplicate claim for payment not clearly labeled as such, or any claim for which payment has already been received from any source, unless clearly labeled as such.
 - b. These crimes are Class C felonies and may be punishable by up to five years' imprisonment and/or a fine not to exceed \$125,000.00.
 6. Racketeering (ORS 166.715 – 166.735)
A person commits the crime of racketeering by engaging in a pattern of activity to collect or receive the proceeds of unlawful debts, or conspire or attempt to do so, and may be held liable for up to three times the amount or three times the gross value gained or the gross loss caused, whichever is greater, plus reasonable attorneys' fees and costs.

V. Related Policies & Procedures, Forms and References

COMP-100 OHSU Health IDS Compliance Plan

Attachment A- Code of Conduct and Conflict of Interest Acknowledgement Form

Attachment B- Annual Conflict of Interest Questionnaire Form

VI. Revision Activity

New P&P/Change/Revision and Rationale	Final Review/Approval	Approval Date	Effective Date of Policy/Change
New Code of Conduct for Subcontractors, Covered Entities, etc.	1/1/2020	1/1/2020	1/1/2020
Revision OHSU Health IDS LLC Board of Directors	6/23/2020	6/23/2020	6/23/2020
Contract changes pages 5 and 8	OHSU Health IDS Regulatory Compliance Committee	3/14/2022	3/14/2022
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	5/16/2022	3/14/2022
Reviewed only, no changes	OHSU Health IDS Regulatory Compliance Committee	3/13/2023	3/13/2023
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	3/28/2023	3/13/2023
Reviewed only, no changes	OHSU Health IDS Regulatory Compliance Committee	9/8/2025	9/8/2025
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	9/24/2025	9/8/2025

ATTACHMENT A

Code of Conduct and Conflict of Interest Acknowledgement Form

As a condition of membership, all Covered Persons with OHSU Health IDS must acknowledge that they have read and clarified any questions or concerns regarding the Code of Conduct and Conflict of Interest Policy.

I acknowledge that that I have read and clarified any questions regarding the Code of Conduct.

Name and title of person completing this form:

Signature

Title

Printed Name

Date

ATTACHMENT B
OHSU Health IDS
ANNUAL CONFLICT OF INTEREST QUESTIONNAIRE

This Questionnaire is to be completed annually by all persons designated as Covered Persons in the Code of Conduct and Conflict of Interest Policy.

1. NAME AND BACKGROUND INFORMATION

a. Name: _____

Address: _____

Telephone Number: _____

Email Address: _____

b. Position(s) with, or relationship to, the Corporation: _____

2. CONFLICT OF INTEREST INFORMATION

a. **Investments.** Identify any investments that you or a member of your family has or had during the last five (5) years in any organization that has, does, or is likely to provide goods or services to, or to compete with, the Corporation:

// None

- b. **Directive or Other Services.** Identify any services that you or a member of your family provides or has provided within the last five (5) years as a director, partner, principal, manager, employee or consultant to any organization that does, has, or is likely to provide goods or services to, or compete with, OHSU Health IDS:

// None

- c. **Interests in Transactions.** Identify any interest that you or a member of your family or any organization in which you have an interest (e.g., a corporation or partnership) has had in any transaction during the last five (5) years, to which OHSU Health IDS or any related organization, was a party (e.g., any loans, sales of goods or services, or guarantees).

// None

- d. **Other.** Identify all other circumstances affecting you or members of your family that might appear to involve a conflict of interest, actual or potential, and any circumstances that could be viewed as use of information relating to OHSU Health IDS' business for personal profit or advantage.

// None

CONFLICT OF INTEREST QUESTIONNAIRE

ACKNOWLEDGMENT AND SIGNATURE

To the best of my knowledge and belief, the above information is true and accurate. I have received a copy of OHSU Health IDS' Conflict of Interest Policy, which I have read and understand, and I hereby agree to comply with it.

DATED this ____ day of _____, 20__.

Signature

Printed Name

OHSU Health IDS, LLC		Policy & Procedure			
Company:	OHSU Health IDS, LLC	Committee Name:	Regulatory Compliance		
Subject:	OHSU Health IDS Exclusion Screening				
P&P Original Effective Date:	1/1/2020	P&P Origination Date:	1/1/2020	P&P Published Date:	1/1/2020
P&P Revision Effective Date:	1/10/2025	P&P Revision Published Date:		9/8/2025	
Reference Number:	COMP-103	Next Review Date:		9/2027	
Product (check all boxes applicable to this policy) <input checked="" type="checkbox"/> Dental <input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Pharmacy <input checked="" type="checkbox"/> Behavioral Health					

I. Policy Statement and Purpose

- A. To ensure that Medicaid payment is not made for items or services furnished or prescribed by a participating provider, employee, subcontractor, or governing body member excluded by the DHHS OIG List of Excluded Individuals and Entities (LEIE) or System for Award Management (SAM). OHSU Health IDS shall conduct reviews of the LEIE and SAM exclusion lists in accordance with Exhibit B, Part 9, Section 18, Para (a) of the CCO Contract.

- B. OHUS Health IDS will not refer Members to or contract with Providers who have been:
 - Have been terminated by the Oregon Health Authority;
 - Have been excluded as a Medicaid provider by another state;
 - Have been excluded as Medicare/Medicaid providers by the Centers for Medicare and Medicaid Services; or
 - Are subject to exclusion for any lawful conviction by a court for which the provider could be excluded under 42 CFR 455.1001.101 and 42 CFR 455.3(b).

- C. Appropriate credentialing, compliance and or Human Resources staff are responsible for LEIE/SAM exclusion checks for OHSU Health IDS medical and ancillary health providers as well as for screening their own employees, Participating Providers, Subcontractors, and governing body members.

II. Definitions

- A. **DHHS:** Department of Health and Human Services.

- B. **List of Excluded Individuals and Entities (LEIE):** The list of individuals and entities that are excluded by the Office of the Inspector General from participating in federally funded health care programs.

- C. **OIG:** Office of Inspector General

- D. **Subcontractor:** 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.

- E. **System for Award Management (SAM):** An electronic database maintained and posted by the General Services Administration containing the list of all parties suspended, proposed for debarment, debarred, declared ineligible, or excluded or disqualified under the non- procurement common rule by agencies, government corporations, or by the Government Accountability Office.
- F. **Participating Provider:** Any practitioner that provides medical, behavioral health or dental services to OHSU Health IDS members.
- G. **Provider:** An individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering provider, or bills, obligates and receives reimbursement on behalf of a rendering provider, also termed a billing provider.

III. Procedures

A. Staff—New Hire

1. Prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, or governing body member, OHSU Health IDS or the partner organization shall review the LEIE, the SAM and conduct individual criminal background checks.
2. If any screened individual is identified on either the LEIE, SAM, or the criminal background check, the individual shall be subject to appropriate corrective action with respect to such screened individual, including preclusion from hiring, termination of employment, removal from the governing body, termination of any contractual relationship, or similar action consistent with the relationship between the parties.
3. The results of these screenings shall be stored by year and accessed as needed.
4. Records of such screenings will be reviewed annually.

B. Providers—New

1. Contracted medical, behavioral health and ancillary health providers shall be screened for exclusion by OHSU Health as part of the initial credentialing process.
2. If a provider is identified on either the LEIE or SAM, OHSU Health IDS shall not pursue a contractual relationship with that provider.
3. 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 on the excluded lists to include the LEIE and the EPLS. Reporting requirements can be met by providing such information to OHA's Provider Enrollment Unit via Administrative Notice.
4. The results of these screenings shall be stored by year and accessed as needed.
5. Records of such screenings shall be reviewed on an annual basis as part of the annual compliance oversight audit.
6. Any providers identified as on the excluded lists of the LEIE or SAM during the credentialing process shall be reported immediately to the following:
 - a. DHHS;
 - b. OIG;
 - c. Oregon Health Authority Program Integrity Audit Unit;
 - d. Health Share of Oregon; and
 - e. The OHSU Health Compliance Officer.
7. The Oregon Health Authority (OHA) conducts site visits for provider types designated as 'moderate'. Provider types designated as 'high' risk must be actively enrolled in Medicare/Medicaid and OHA relies on Medicaid site visit and fingerprint background check screening for these provider types. OHSU Health IDS will not enroll a provider type classified as 'moderate' or 'high' risk without OHA or CMS enrollment.

C. Monthly Screening

1. OHSU Health IDS, its subcontractors and participating providers will review the LEIE and the SAM on a monthly basis to ensure that employees, temporary employees, volunteers, consultants, governing body members, subcontractors and participating providers are not excluded or have become excluded from participation in federal programs.
2. If a screened individual is identified on either the LEIE list or the SAM, OHSU Health IDS and its subcontractors and participating providers will take appropriate corrective action with respect to such screened individual, including termination of employment, removal from the board of directors, termination of any contractual relationship, or similar action consistent with the relationship between the parties.
3. 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 monthly screening process, who are on the excluded lists to include the LEIE and the EPLS. OHSU Health IDS will notify Health Share within 2 days of any providers or employees excluded from federal programs.
4. Screening results shall be stored by month and can be accessed as needed.
5. All OHSU Health IDS subcontractors and participating providers are required to attest, on a yearly basis, that all employees, temporary employees, volunteers, consultants and governing body members have not been excluded from participation in federal programs and are screened for exclusion on a monthly basis.

IV. Related Policies & Procedures, Forms and References

OHSU Health IDS Compliance Plan

V. References

2007 Federal Sentencing Guidelines - §8B2.1(b)(3)

VI. Revision Activity

New P&P/Change/Revision and Rationale	Final Review/Approval	Approval Date	Effective Date of Policy/Change
New Provider Directory Policy and Procedure	OHSU Health Services Clinical Value and Transformation	1/1/2020	1/1/2020
Minor grammar revisions	Clinical Value and Transformation Committee	8/20/2020	8/20/2020
Board Oversight	OHSU Health IDS Board of Directors	8/25/20	8/20/20
Addition of Section III B 6 regarding fingerprint and background checks prior to credentialing	IDS Regulatory Compliance Committee	1/10/2022	1/10/2022
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	1/25/2022	1/10/2022
Inserted criminal background check language per Health Share audit requirement Section III A 1 & 2	OHSU Health IDS Regulatory Compliance Committee	11/14/2022	11/14/2022
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	11/29/2022	11/14/2022
Annual Review, no changes.	OHSU Health IDS Regulatory Compliance Committee	11/13/2023	11/13/2023

Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	12/12/2023	11/13/2023
Updated OHSU IDS to OHSU Health IDS. Section III, C(3) notify HSO within 2 days of provider being excluded from participating in government programs	OHSU Health IDS Regulatory Compliance Committee	9/8/2025	9/8/2025
Board Oversight, Consent Agenda	OHSU Health IDS Regulatory Compliance Committee	9/24/2025	9/8/2025

OHOHSU Health IDS, LLC		Policy & Procedure			
Company:	OHSU Health IDS, LLC	Committee Name:	Regulatory Compliance		
Subject:	OHSU Health IDS Workforce Training				
P&P Original Effective Date:	1/1/2020	P&P Origination Date:	1/1/2020	P&P Published Date:	1/1/2020
P&P Revision Effective Date:	12/12/2023	P&P Revision Published Date:		9/8/2025	
Reference Number:	COMP-113	Next Review Date:		9/2026	
Product (check all boxes applicable to this policy) <input type="checkbox"/> Dental <input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy <input type="checkbox"/> Behavioral Health					

I. Policy Statement and Purpose

OHSU Health IDS provides and requires annual attendance at training and education for the compliance officer, senior management, other members of the OHSU Health IDS workforce, subcontractors if applicable, OHSU Health IDS board members and participating providers regarding its fraud, waste, and abuse policies and procedures.

- a) Such training and education includes, without limitation, the right to be protected as a whistleblower, pursuant to Section 1902(a)(68) of the Social Security Act for reporting any fraud, waste, or abuse.
- b) OHSU Health IDS’s system for training and education must provide all information necessary for its employees, Subcontractors if applicable, Directors and Participating Providers to fully comply with the FWA requirements of the Contract.
- c) 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.
- d) Includes immediately reporting excluded providers identified during credentialing to HHS-OIG
- e) includes information regarding Oregon specific laws, such as the Oregon False Claims Act (ORS 180.755) and the Oregon Medicaid anti-fraud statute (ORS 411.675).
- f) Additionally, it includes 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 and
 - (2) the prohibition of employing, subcontracting, or otherwise being affiliated with (or any combination or all the foregoing) sanctioned individuals.

II. Procedure

- A. New members of the OHSU Health IDS workforce will receive training on the code of conduct and the ethics and compliance program within 60 days of the initiation of their relationship with OHSU Health IDS.

- B. OHSU Health IDS requires any Subcontractors, if applicable, to comply with and perform all of the same obligations, terms and conditions of Contract as set forth in Ex. B, Part 9. Such annual education and training includes material relating to, as set forth in 42 CFR §§438.608(b) and 438.214(d):
 - a. The credentialing and enrollment of Providers and Subcontractors; and
 - b. The prohibition of employing, Subcontracting or otherwise being Affiliated with (or any combination or all of the foregoing) sanctioned individuals.

- C. All OHSU Health IDS staff, including the Board of Directors and OHSU providers receive annual compliance and FWA training. Attendance is mandatory for all staff including the compliance officer, senior management, and those responsible for credentialing providers. The new hire and annual FWA training cover the following:
 - a. Definition and examples of FWA
 - b. Understanding Federal and State FWA Laws
 - c. Exclusion Provisions
 - d. Credentialing and Enrollment of Providers and Subcontractors
 - e. Detection, Prevention and Correction of FWA
 - f. Key Indicators of FWA
 - g. Reporting FWA
 - h. Non-Retaliation/Whistleblower protection

- D. Subcontractors, as applicable, shall be required to attest that they offer their own training that covers these topics. In the event OHSU Health IDS subcontractors do not offer equivalent training, OHSU Health IDS will require subcontractors to take OHSU Health IDS's FWA /compliance training module.

III. Related Policies & Procedures, Forms and References

Federal Sentencing Guidelines §8B2.1.(b)(2) and §8B2.1.(b)(4)
 42 CFR §§438.608(b) and 438.214(d)

IV. 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 Policy	Regulatory Compliance	1/10/2022	1/10/2022
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	1/25/2022	1/10/2022
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	12/12/2023	12/12/2023
Review only, no changes.	OHSU Health IDS Compliance Committee	9/8/2025	9/8/2025
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	9/24/2025	9/8/2025

OHSU Health IDS, LLC		Policy & Procedure			
Company:	OHSU Health IDS, LLC	Committee Name:	IDS Regulatory Committee		
Subject:	OHSU Health IDS Whistleblower Protections				
P&P Original Effective Date:	1/1/2020	P&P Origination Date:	1/1/2020	P&P Published Date:	1/1/2020
P&P Previous Revision Effective Date:	3/18/2025	P&P Revision Published Date:	9/8/2025		
Reference Number:	COMP-114	Next Review Date:	9/2026		
Product (check all boxes applicable to this policy) <input type="checkbox"/> Dental <input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Pharmacy <input checked="" type="checkbox"/> Behavioral Health					

I. Policy Statement and Purpose

- A. OHSU Health IDS requires directors, officers and employees to observe high standards of business and personal ethics in the conduct of their duties and responsibilities in accordance with the Civil False Claims Act. As employees and representatives of OHSU Health IDS, we must practice honesty and integrity in fulfilling our responsibilities and comply with all applicable laws and regulations.
- B. Reporting Responsibility
 This policy is intended to encourage and enable employees and others to raise serious concerns internally so that OHSU Health IDS can address and correct inappropriate conduct and actions. It is the responsibility of all Board members, officers, directors, employees and volunteers to report concerns about violations of OHSU Health IDS Code of Conduct or suspected violations of law or regulations that govern OHSU Health IDS operations.
- C. No Retaliation
 It is contrary to the values of OHSU Health IDS for anyone to retaliate against any Board member, officer, director, and employee or volunteer who in good faith reports an ethics violation, or a suspected violation of law, such as a complaint of discrimination, or suspected fraud, or suspected violation of any regulation governing the operations of OHSU Health IDS. An employee who retaliates against someone who has reported a violation in good faith is subject to discipline up to and including termination of employment.
- D. OHSU Health IDS will provide information in its employee handbook a specific discussion of the applicable fraud, waste, and abuse federal and State laws, the rights of employees to be protected as whistleblowers, and the OHSU Health IDS’s policies for detecting and preventing fraud, waste, and abuse.
- E. Such disclosures are required of OHSU Health IDS and its subcontractors if they receive or make payments of at least five million dollars (\$5,000,000) annually because of its performance under their contract with OHSU Health IDS.

II. Procedure

- A. OHSU Health IDS has an open-door policy and requires that employees share their questions, concerns, suggestions or complaints with their supervisor. If an employee is not comfortable speaking with their supervisor or are not satisfied with their supervisor’s response, they are

encouraged to speak with the designated Compliance Officer, an Executive Director, or a board member. Supervisors and managers are required to report complaints or concerns about suspected ethical and legal violations in writing to the OHSU Health IDS Compliance Officer or other Director as indicated above, who has the responsibility to investigate all reported complaints. Employees with concerns or complaints may also submit their concerns in writing.

B. OHSU Health IDS Designated Compliance Officer

The OHSU Health IDS Compliance Officer is responsible for ensuring that all complaints about unethical or illegal conduct are investigated and resolved. The Compliance Officer will advise the Chief Executive Officer and/or the Board of Directors of all complaints and their resolution.

C. Accounting and Auditing Matters

The OHSU Health IDS Compliance Officer shall immediately notify the OHSU Health IDS the Finance Committee of any concerns or complaint regarding corporate accounting practices, internal controls or auditing and work with the committee until the matter is resolved.

D. Acting in Good Faith

Anyone filing a written complaint concerning a violation or suspected violation must be acting in good faith and have reasonable grounds for believing the information disclosed indicates a violation. Any allegations that prove not to be substantiated and which prove to have been made maliciously or knowingly to be false will be viewed as a serious disciplinary offense.

E. Confidentiality

Violations or suspected violations may be submitted on a confidential/anonymous basis by the complainant via the hotline at 1-877-733-8313 or www.ohsu.edu/hotline. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation.

F. Handling of Reported Violations

The OHSU Health IDS Compliance Officer will notify the person who submitted a complaint and acknowledge receipt of the reported violation or suspected violation. All reports will be promptly investigated and appropriate corrective action will be taken if warranted by the investigation.

III. Related Policies & Procedures, Forms and References

Section 1902(a)(68) of the Social Security Act

IV. 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 Policy to be included in FWA Handbook per 2020 CCO contract	OHSU Health IDS Clinical Value and Transformation Committee	3/18/2020	1/1/2020
Policy section A, B, C added and Procedure added for 2022	OHSU Health IDS Regulatory Compliance Committee	7/11/2022	7/11/2022
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	8/23/2022	7/11/2022
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	12/12/2023	12/12/2023

Review only, no changes	OHSU Health IDS Regulatory Compliance Committee	9/8/2025	9/8/2025
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	9/24/2025	9/8/2025

OHSU Health IDS, LLC		Policy & Procedure			
Company:	OHSU Health IDS, LLC	Committee Name:	Regulatory Compliance		
Subject:	OHSU Health IDS Auditing, Monitoring and Service Verification				
P&P Original Effective Date:	1/1/2020	P&P Origination Date:	1/1/2020	P&P Published Date:	1/1/2020
P&P Previous Revision Effective Date:	1/10/2025	P&P Revision Published Date:		9/8/2025	
Reference Number:	COMP-117	Next Review Date:		9/2026	
Product (check all boxes applicable to this policy) <input type="checkbox"/> Dental <input checked="" type="checkbox"/> Medical <input type="checkbox"/> Pharmacy <input type="checkbox"/> Behavioral Health					

I. Policy Statement and Purpose

- A. 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 Regulatory Compliance Committee and the board of directors.
- B. OHSU Health IDS will routinely verify whether services that have been represented to have been delivered by network Providers were received. Such verification will be made by mailing service verification letters to Members, sampling, hotline reports or other methods.

II. Procedure

- A. Provider Audit:
 - 1. OHSU Health IDS will review a sample of participating provider health records on a quarterly basis to determine if what was billed to OHSU Health IDS matches the clinical record.
 - 2. If non-compliant practices are identified that result in documentation errors in the health records, a corrective action plan shall be developed and providers will be notified.
 - 3. OHSU Health IDS will re-audit a sample of records after an appropriate period of time to determine if the corrective action has been effective. If not, additional corrective action shall be taken and re-audited.
 - 4. If errors in documentation have resulted in inaccurate encounter data reporting or billing for services, those reports shall be corrected or the services shall be re-billed or refunded.
- B. Service Verification: OHSU Health IDS will routinely verify whether services that have been represented to have been delivered by Participating Providers and Subcontractors were received by Members, to investigate incidents where services were not delivered or where Member paid out of pocket for services, and collect any associated Overpayments. Such verification of services must be made by:
 - 1. OHSU Health IDS will sample 1% of all paid claims on a monthly basis.
 - 2. Based upon that sample OHSU Health IDs will send service verification letters to members asking them to verify they received the services billed.
 - 3. The Service Verification Notice must include, based on information from OHSU Health IDS'

- claims payment system, at a minimum, all of the minimum
- a. The services furnished
 - b. The name of the provider furnishing the services
 - c. The date on which the services were furnished
 - d. The amount of the payment made by the Member, if any, for the service.
4. The sample will exclude specially protected information such as genetic, mental health, alcohol and drug or HIV/AIDS
 5. Members that do not recognize or did not receive services billed are asked to reply as such with self-addressed, postage paid envelope.
 6. Once received, OHSU Health IDS staff will reach out to the provider in question to ensure services were received or if an error or fraud occurred.
 7. If non-compliant practices are identified that result in documentation errors in the health records, a corrective action plan shall be developed and providers will be notified.
 8. If errors in documentation have resulted in inaccurate encounter data reporting or billing for services, those reports shall be corrected or the services shall be re-billed or refunded.

III. Related Policies & Procedures, Forms and References

Federal Sentencing Guidelines §8B2.1.(5)(B)

Health Services Division CCO 2.0 Contract Exhibit B Part 9 Section 11 b, Section 12 a and Section 18 b

IV. 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 CCO contract requirements on what must be included in the Service Verification Notices	OHSU Health IDS Regulatory Compliance Committee	1/10/2022	1/10/2022
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	1/25/2022	1/10/2022
Changes made due to 2022 contract changes	OHSU Health IDS Regulatory Compliance Committee	3/14/2022	3/14/2022
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	5/16/2022	3/14/2022
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	12/12/2023	12/12/2023
Review only, no changes.	OHSU Health IDS Regulatory Compliance Committee	9/8/2025	9/8/2025
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	9/24/2025	9/8/2025

OHSU Health IDS LLC		Policy & Procedure			
Company:	OHSU Health IDS LLC	Committee Name:	Regulatory Compliance		
Subject:	OHSU Health IDS Retention and Reporting of Overpayments				
P&P Original Effective Date:	1/1/2020	P&P Origination Date:	1/1/2020	P&P Published Date:	1/1/2020
P&P Revision Effective Date:	1/10/2025	P&P Revision Published Date:		9/8/2025	
Reference Number:	COMP-118	Next Review Date:		9/2026	
Product (check all boxes applicable to this policy) <input type="checkbox"/> Dental <input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Pharmacy <input type="checkbox"/> Behavioral Health					

I. Policy Statement and Purpose

- A. OHSU Health IDS will self-report to Health Share of Oregon and the Oregon Health Authority (OHA) within sixty (60) days of its identification any overpayment it received from Health Share of Oregon under the Integrated Delivery System Agreement or any other contract, agreement, or MOU entered into by OHSU Health IDS.

- B. OHSU Health IDS will report to Health Share and OHA any overpayments made to providers, subcontractors, or other third parties. Reporting occurs regardless of whether such overpayments were made because of the self-reporting by a provider, subcontractor, other third party, or whether identified by OHSU Health IDS. In addition, regardless of whether such overpayment was the result of a fraud, waste, or abuse or an accounting error. If identification of overpayment was the result of self-reporting to OHSU Health IDS by a provider, subcontractor, other third party, OHSU Health IDS will report and return such overpayment within sixty (60) days of the provider's, subcontractors, or other third party's identification of the overpayment. If OHSU Health IDS identifies an overpayment because of an audit or investigation, such overpayment will be reported to Health Share and OHA promptly, but in no event more than seven (7) days after identifying such overpayment. If OHSU Health IDS suspects an overpayment identified during an audit or investigation is due to fraud, waste, or abuse, such overpayment will be reported in accordance with Sec. 18, Ex. B, Part 9, Section 18 of the CCO Contract. All such reports made by the provider, subcontractor, or other third party must include a written statement identifying the reason(s) for the return of the excess payment.

- C. OHSU Health IDS will report all overpayments identified or recovered, regardless of whether the overpayments were the result of self-reporting or the result of a routine or planned audit or other review, on the quarterly and annual financial reports required under the CCO Contract.

- D. Health Share/OHA and OHSU Health IDS Audits of Network Providers
 - 1. If Health Share/OHA conducts an audit of OHSU Health IDS's Providers or the Providers' Encounter Data that results in a finding of overpayment, OHA 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 shall have the right, at its discretion, to pursue recovery of the overpayments made by OHSU Health IDS to the applicable providers. OHA will provide OHSU Health IDS' Contract Administrator with Administrative Notice of its findings and its decision relating to means of and timeframe for recovery of any finding of overpayment.

2. If Health Share/OHA conducts an audit of OHSU Health IDS's Providers or the Providers' Encounter Data that results in an administrative or other non-financial finding, OHSU Health IDS will use the information included in the final audit report to rectify any identified billing issues with its providers and pursue financial recoveries for improperly billed claims if applicable.
3. If OHSU Health IDS or its subcontractors conduct audits of OHSU Health IDS's providers or providers' encounter data that results in a finding of overpayment, OHSU Health IDS will return to OHA 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.
4. In addition to reporting all identified and recovered overpayments made to providers, subcontractors, or other 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:
 - a. 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.
 - b. 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 must be made in accordance with and made available to OHA and other parties in accordance with Ex. D, of the OHA Health Plan Services Contract.
 - c. In the event that 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 must return to OHA 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.
 - d. Examples of Overpayment types that might be made to Providers, Subcontractors, or other third parties include, but are not limited to, the following:
 - i. Payments for Non-Covered Services,
 - ii. Payments in excess of the allowable amount for an identified covered service,
 - iii. Errors and non-reimbursable expenditures in cost reports,
 - iv. Duplicate payments, and
 - v. Receipt of Medicaid payment when another payer had the primary responsibility for payment, and is not included in an automated TPL retroactive recovery process.
 - e. OHSU Health IDS will not retain any overpayments made to any provider or any subcontractor that are recovered as a result of (i) claims brought under the State or federal False Claims Acts (ii) a judgment or settlement arising out of or related to litigation involving claims of fraud, or (iii) through government investigations, such as amounts recovered by PIAU or MFCU or any other State or federal governmental entity, regardless of whether OHSU Health IDS referred the matter to such parties.
5. Using the FWA Report Template (found on the OHA 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 the 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 OHSU Health IDS on its subcontractors or providers. The quarterly FWA Report is due thirty (30) days following the end of each quarter and will be provided to Health Share via the Health Share Bridge.

II. Related Policies & Procedures, Forms and References

Oregon Health Authority Health Services Division CCO Contract

III. Revision Activity

New P&P/Change/Revision and Rationale	Final Review/Approval	Approval Date	Effective Date of Policy/Change
New policy to be included in FWA Handbook per 2020 CCO contract	OHSU HEALTH IDS Quality Improvement Committee	03/18/2020	01/01/2020
Review only, minor clarity edits	OHSU Health IDS Regulatory Compliance	1/10/2022	1/10/2022
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	1/25/2022	1/10/2022
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	12/12/2023	12/12/2023
Review only, no changes	OHSU Health IDS Regulatory Compliance	9/8/2025	9/8/2025
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	9/24/2025	9/8/2025

OHSU Health IDS, LLC		Policy & Procedure			
Company:	OHSU Health IDS, LLC	Committee Name:	Regulatory Compliance		
Subject:	OHSU Health IDS Reporting Fraud, Waste and Abuse				
P&P Original Effective Date:	1/1/2020	P&P Origination Date:	1/1/2020	P&P Published Date:	1/1/2020
P&P Previous Revision Effective Date:	1/1/2025	P&P Revision Published Date:		9/8/2025	
Reference Number:	COMP-119	Next Review Date:		9/2026	
Product (check all boxes applicable to this policy) <input type="checkbox"/> Dental <input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy <input type="checkbox"/> Behavioral Health					

Section

I. Policy Statement and Purpose

- A. OHSU Health IDS will have and publicize a system, which may include mechanisms that allow for anonymity or confidentiality, whereby the organization's workforce may report or seek guidance regarding potential fraud, waste or abuse or actual criminal conduct without fear of retaliation.

- B. Role of the False Claims Law in Preventing Fraud, Waste, and Abuse
 - 1. The Centers for Medicare & Medicaid Services (CMS) defines "fraud" as the intentional deception or misrepresentation that an individual knows to be false (or does not believe to be true) and makes, knowing that the deception could result in an unauthorized benefit to himself or another person. CMS defines "abuse" as provider incidents or practices that are inconsistent with sound medical practice and/or that might result in unnecessary costs, improper payment, or payment for services that are medically unnecessary or fail to meet professionally recognized standards of care.
 - 2. Federally enacted criminal and civil laws allow criminal, civil and administrative penalties for submitting false or fraudulent claims for payment or approval, to federal or state governments or to private payers. Under these laws, government authorities have broad power to investigate and prosecute potentially fraudulent activities; and the laws include anti-retaliation provisions for individuals who make good faith reports of waste, fraud and abuse.

- C. Federal Civil False Claims Act
 - 1. The Civil False Claims Act (31 U.S.C. §3729 *et seq.*) imposes civil liability on any person who:
 - a. Knowingly presents, or causes to be presented, a false or fraudulent claim, record or statement for payment or approval;
 - b. Conspires to defraud the government by getting a false or fraudulent claim allowed or paid;
 - c. Uses a false record or statement to avoid or decrease an obligation to pay the Government; or
 - d. Acts fraudulently in other ways the statute enumerates.

2. The Civil False Claims Act (FCA) defines the term "knowingly" to include a person who has actual knowledge of information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.
3. The term "claim" includes any request or demand for money or property if the United States Government provides any portion of that requested or demanded.
4. Potential civil liability under the FCA currently includes penalties of between five thousand five hundred and eleven thousand dollars per claim, treble damages, and the costs of any civil action brought to recover such penalties or damages.
5. The Attorney General of the United States is required to investigate FCA violations, and may bring a civil action against a person. Before filing suit, the Attorney General may issue an investigative demand requiring production of documents, written answers, or oral testimony.
6. The FCA also provides for actions by private persons (*qui tam* lawsuits) who can bring a civil action in the name of the government for a violation of the Act. Generally, such action may not be brought more than six years after the violation, but in no event more than ten. When the action is filed it remains under seal for at least sixty days. The United States Government may choose to intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing or settling the action. If the Government chooses not to intervene, the party who initiated the lawsuit has the right to conduct the action.
7. In the event the government proceeds with the lawsuit, the *qui tam* plaintiff may receive fifteen to twenty-five per cent of the proceeds of the action or settlement. A *qui tam* plaintiff who proceeds with the action without the government may receive twenty-five to thirty per cent of the amount recovered. In either case, the plaintiff also may receive an amount for reasonable expenses plus reasonable attorneys' fees and costs.
8. However, if the civil action is frivolous, clearly vexatious, or brought primarily for harassment, the plaintiff may have to pay fees and costs to the defendant. If the plaintiff planned or initiated the violation, the share of proceeds may be reduced and, if found guilty of a crime associated with the violation, no share will be awarded the plaintiff.
9. Examples of a False Claim
 - a. Billing for items or services not performed
 - b. Falsifying information in the resident's records
 - c. Double billing for items or services

D. Whistleblower Protection

1. For employees, the Civil False Claims Act provides protection from retaliation. An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in terms and conditions of employment because of lawful acts to further an action under the FCA may bring an action in Federal District Court to seek reinstatement, two times the amount of back pay plus interest, and other costs, damages, and fees.

E. Federal Program Fraud Civil Remedies Act of 1986

1. The Program Fraud Civil Remedies Act of 1986 ("Administrative Remedies for False Claims and Statements" at 38 U.S.C. §3801 *et seq.*) establishes an administrative remedy against any person who presents or causes to be presented a claim or written statement that the person knows or has reason to know is false, fictitious or fraudulent due to an assertion or omission to certain federal agencies (including the Department of Health and Human Services).
2. The term "knows or has reason to know" is defined in the Act as a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.
3. The term "claim" includes any request or demand for property or money, e.g., grants, loans, insurance or benefits, when the United States Government provides or will reimburse any portion of what is asked.
4. A federal department authority may investigate and, with the Attorney General's approval, commence proceedings if the claim is less than one hundred and fifty thousand dollars. A hearing must begin within six years from the date the claim is submitted. The Act allows civil monetary sanctions to be imposed, including penalties of five thousand five hundred dollars per claim and an assessment, in lieu of damages, of two time the amount of the original claim.

II. Definitions

N/A

III. Procedure

A. OHSU Health IDS encourages members of its workforce, providers, subcontractors and providers to report suspected FWA to OHSU Health IDS. OHSU Health IDS staff, providers, subcontractors and providers may submit FWA or compliance concerns in any of three ways.

- Via a toll-free hotline (855-801-2991) that allows OHSU Health IDS employees, providers, subcontractors and providers to report or seek guidance anonymously or confidentially regarding potential or actual criminal conduct without fear of retaliation.
- Via OHSU Health IDS's online anonymous allegation platform Ethics Point that allows OHSU Health IDS employees, providers, subcontractors and providers to report or seek guidance anonymously or confidentially regarding potential or actual criminal conduct without fear of retaliation.
- Or by contacting OHSU Health IDS's Compliance Officer by phone or email.

Once a compliance or FWA allegation is received by one of the methods above, below are the steps taken to triage the issue regardless of the method of notification.

- The allegation is received by the OHSU Health IDS compliance officer via one of the methods above.
 - Issues related to potential FWA :
 - Allegations of FWA are sent by the Compliance Officer to the SIU for investigation.

- The SIU conducts an initial investigation and either closes the case if the allegation cannot be supported or opens PI Audit if there are potential FWA issues present.
 - Once a PI Audit is initiated the normal PI Audit process is undertaken as outlined in this policy.
 - Throughout the process the SIU and Compliance Officer are in contact regarding resolution and ensure appropriate corrective or follow up actions are undertaken.
 - Resolution of reports may not be able to be shared with reporters, but reporters are informed the case has been received and is being worked.
- Issues related to general Medicaid Compliance:
 - Issue is triaged by Compliance Officer
 - Compliance Officer will identify internal departments that need to be consulted to address the concern
 - Compliance Officer will conduct investigation to determine validity
 - If a compliance concern exists, Compliance Officer will work with affected departments or individual to identify root cause of non compliance.
 - Corrective action may be issues depending on severity of the issue
 - Compliance Officer will monitor issue to ensure non compliance has been corrected
 - Resolution of reports may not be able to be shared with reporters, but reporters are informed the case has been received and is being worked.

OHSU Health IDS members are provided information in their member handbook regarding definitions of fraud waste and abuse.

OHSU Health IDS will maintain the privacy and anonymity of all reporting parties except where legally proscribed. As described above, members that wish to bring forward Fraud, Waste and Abuse concerns anonymously may do so by using the OHSU Health IDS's toll free Hotline or may also submit anonymous allegation online via Ethics Point. 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. When suspected or potential misconduct, compliance reports or potential or actual non-compliance is reported, the allegations will be promptly investigated. There is no difference in process whether the issue originates from employees, providers, subcontractors or members. Misconduct may be directly reported to the Compliance Department via phone or email. Additionally, employees, members, providers and subcontractors may also report misconduct via OHSU Health IDS's EthicsPoint compliance reporting website. Any allegation, whether reported through email, phone or EthicsPoint are recorded and tracked in EthicsPoint. Responses are provided to responders as appropriate. In the event that an investigation reveals misconduct, corrective action will be immediately initiated. OHSU Health IDS will assure that reasonable steps are taken to respond to and prevent further misconduct, including the identification of any systemic shortcomings that compromise the deterrent effect of its Ethics and Compliance Program. If necessary, appropriate modifications will be made to the Program.

B. Examples and characteristics of Fraud Waste and Abuse Include, without limitation:

- a. Providers, other CCOs, or Subcontractors that intentionally or recklessly report Encounters or services that did not occur, or where products were not provided.
- b. Providers, other CCOs, or Subcontractors that intentionally or recklessly report overstated or up coded levels of service.
- c. Providers, other CCOs, or Subcontractors intentionally or recklessly billed OHSU Health IDS or OHA more than the Usual Charge to non-Medicaid Recipients or other insurance programs.
- d. 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.

- e. Providers, other CCOs, or Subcontractors that intentionally or recklessly make false statements about the credentials of persons rendering care to Members.
- f. 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.
- g. 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 OHSU Health IDS, or Applicable Law.
- h. 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 OHSU Health IDS's payment to the Provider, in violation of Applicable Law.
- i. Providers, other CCOs, or Subcontractors intentionally or recklessly submitted a claim for payment when such party knew the claim: (i) had already been paid by OHA or OHSU Health IDS, (ii) had already been paid by another source.
- j. Any case of theft, embezzlement or misappropriation of Title XIX or Title XXI program money.
- k. Any practice that is inconsistent with sound fiscal, business, or medical practices, and which: (i) results in unnecessary costs, (ii) results in reimbursement for services that are not medically necessary, or (iii) fails to meet professionally recognized standards for health care.
- l. Evidence of corruption in the Enrollment and Disenrollment process, including efforts of OHSU Health IDS employees, State employees, other CCOs, or Subcontractors to skew the risk of unhealthy Member or potential Members toward or away from OHSU Health IDS or any other CCO.
- m. Attempts by any individual, including OHSU Health IDS's employees, Providers, Subcontractors, other CCOs, OHSU Health 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.

C. Reporting Fraud and Abuse

1. OHSU Health IDS will promptly refer all suspected cases of fraud, waste and abuse, including fraud by employees, participating providers, members and subcontractors or any other third parties to the Medicaid Fraud Control Unit (MFCU) and the OHA Office of Program Integrity (OPI).
2. Reporting will be made promptly but in no event more than seven (7) days after OHSU Health IDS is initially made aware of the suspicious case.
3. When sending a referral to OPI and MFCU OHSU Health IDS will use the FWA Referral Form provided by OHA, available on the OHA contract forms website. The FWA Referral Form must, when sent to OPI and MFCU, include, at a minimum, the following information:
 - i. OHSU Health IDS's name;
 - ii. Name of Provider or Member;
 - iii. The suspected issue or allegation;
 - iv. The information or data OHSU Health IDS has already reviewed; and planned next steps for further investigation

4. When sending any written communication or referral sent to OPI and MFCU OHSU Health IDS will include:
 - i. OHSU Health IDS's name;
 - ii. OHSU Health IDS's Medicaid Contract number
 - iii. Which entity (HealthShare or OHSU Health IDS), and the name and title of the individual within the entity who is performing the investigation, PI Audit, or other review, and their contract information;
 - iii. HealthShare may provide the above information to OPI by completing the FWA Referral Form.
5. Individual whistleblowers or any other person who makes a report of suspected Fraud, Waste, Abuse or non compliance to OHSU Health IDS will not be required to use the FWA Referral Form or be required to include identifying information in their anonymous reports. All anonymous FWA reporting will be accepted by OHSU Health IDS, its subcontractors and its providers.
6. 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, upon notification of an investigation by MFCU, will suspend payments to the provider unless MFCU determines there is good cause not to suspend payments or to suspend payments in part.
7. OHSU Health IDS shall cooperate in good faith with the MFCU and the DHS Fraud Unit (or their designees) and provide copies of reports or other documentation, allow them to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities as required to investigate an incident of fraud or abuse. In the event that OHSU Health IDS reports suspected fraud, or learns of an MFCU or OPI, OHSU Health IDS will not notify or otherwise advise its subcontractors of the investigation so as not to compromise the investigation.
8. Using the FWA Report Template (located 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 HealthShare with quarterly and annual reports of all PI Audits performed by OHSU Health IDS per the due established by Health Share to ensure compliance with OHA deliverable timeframes. The Annual FWA Audit Report and FWA Referrals and Investigation 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 OHSU Health IDS or providers. The quarterly FWA Audit Report and Referral and Investigation Report is due thirty (30) days following the end of each quarter and will be provided to OHA via the Contract Deliverable Portal. For both the Quarterly and Annual FWA Audit Reports, OHSU Health IDS will report all PI Audits opened, in-process and closed during the reporting period. OHSU Health IDS will also provide to OHA, with Quarterly FWA Report, a copy of the final PI Audit report for each PI Audit identified in the FWA Audit Report as closed during the reporting period, as well as any other final PI Audit Reports that have not been submitted. Additionally, both reports will include all of OHSU Health IDS's open, ongoing and closed preliminary investigations or suspected and credible cases.

9. Using the template provided by OHA OHSU Health IDS will provide to HealthShare, an quarterly summary report of Referrals, and cases investigated. The report will include, regardless of OHSU Health IDS's own suspicions or lack thereof, any incident with any of the characteristics listed in Exhibit B, Part 9, Section 17 and will include all open and closed preliminary investigations of suspected and credible cases. The annual FWA Referral and Investigations Report will be provided to HealthShare per the due established by Health Share to ensure compliance with OHA deliverable timeframes.. 10. OHA will notify HealthShare, via Administrative Notice, within sixty (60) days from the due date, or within sixty (60) days from the received date if after the due date, of the compliance status of its Annual FWA Audit and Referrals and Investigations Report. In the event OHA disapproves of the Annual FWA Audit Report or Referrals and Investigations Report (including one or more of HealthShare's final PI Audit reports for audits identified in the Annual FWA Audit Report as closed) for failing to meet the terms and conditions of this Contract and any other Applicable Laws, OHSU Health IDS shall, in order to remedy the deficiencies, follow the process set forth in Sec. 5, Ex. D of this Contract. OHSU Health IDS will promptly correct any errors at the direction of HealthShare based upon OHA feedback.
11. In addition, OHA OPI may review HealthShare's Quarterly and Annual FWA Audit Reports, Quarterly and Annual Referral and Investigations Report and copies of final PI Audit reports and request PI Audit supporting documents, Exhibit B, Part 9, Section 20 of the CCO Contract. OHSU Health IDS will cooperate with any requests from HealthShare based upon OHA Feedback.
12. In addition to the annual and quarterly reporting OHSU Health IDS will report, regardless of its own suspicions or lack thereof, to the MFCU an incident with any of the characteristics listed in Section III (B) above. All reporting must be made as set forth below in this policy.
13. Subject to 42 C.F.R. §455.23, in the event OHA determines that a credible allegation of Fraud has been made against OHSU Health IDS, OHA will have the right to suspend, in whole or in part, payments made to OHSU Health IDS. In the event OHA determines that a credible allegation of Fraud has been made against OHSU Health IDS's Subcontractors, OHA will also have the right to direct OHSU Health IDS to suspend, in whole or in part, the payment of fees to any and all such Subcontractors. Subject to 42 C.F.R. §455.23(c) suspension of Payments or other sums may be temporary. until either OHA, or the prosecuting authorities determine there is insufficient evidence of fraud, or legal proceedings related to alleged fraud are completed. OHA has the right to forgo suspension and continue making Payments, or refrain from directing OHSU Health IDS to suspend payment of sums to its Subcontractors, if certain good cause exceptions are met as provided for under 42 C.F.R. §455.23(e). Thus including performing check holds, withholding payments, restricting future enrollment and payments to Subcontractors. In the event OHA determines a credible allegation of Fraud has been made against a Subcontractor, OHSU Health IDS will cooperate with OHA to determine, in accordance with the criteria set forth in 42 C.F.R. §455.23, whether sums otherwise payable by OHSU Health IDS to such Subcontractor, must be suspended or whether good cause exists not to suspend such payments.
14. OHSU Health IDS if made aware of any suspected FWA by a Participating Provider, Subcontractor, or its own employees, will report the incident to MFCU and OPI as required under Exhibit B, Part 9. Such reporting may be made by any methods listed below for MFCU and OPI

Medicaid Fraud Control Unit (MFCU)

Oregon Department of Justice
 100 SW Market Street Portland, OR
 97201
 Phone: 971-673-1880
 Fax: 971-673-1890
 Secure email: Medicaid.Fraud.Referral@doj.state.or.us

OHA Office of Program Integrity (OPI)

500 Summer St NE E-36
 Salem, OR 97301

Secure email: OPI.Referrals@oha.oregon.gov
 Hotline: 1-888-FRAUD01 (888-372-8301)
<https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx>

15. OHSU Health IDS , if made aware of suspected Fraud or Abuse by a Member (e.g., a Provider reporting Member FWA) will promptly report the incident to the ODHS Fraud Investigation Unit (FIU). Such reporting may be made by mail, phone, or facsimile transmission using the following contact information:

DHS Fraud Investigation

PO Box 14150
 Salem, OR 97309
 Hotline: 1-888-FRAUD01 (888-372-8301)
 Fax: 503-373-1525 Attn: Hotline
<https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx>

16. OHSU Health IDS will include the above contact information for MFCU, OPI DHS/OHA Fraud Investigation in its FWA Prevention Handbook and its Member Handbook. Additionally, the following relating to FWA will be included in the Member Handbook:

- a) A statement or narrative that articulates contractor’s commitment to:
 - ii. Prevent FWA
 - iii. Comply with all applicable Laws, including, without limitation, the State’s False Claims Act and the Federal False Claims Act;
- b) Examples of Fraud, Waste, and Abuse;
- c) Where and how to report Fraud, Waste, and Abuse; and
- d) A description of the process for members to report FWA anonymously and to be protected under the applicable Whistleblower laws.

17. OHSU Health IDS requires all subcontractors to comply with this policy and perform all obligations, terms and conditions as OHSU Health IDS as set forth in Ex B, Part 9. Additionally, all subcontractors will be provided with the OHSU Health IDS FWA Handbook.

I. 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

Added Section II D 5 due to new CCO Contract changes	OHSU Health IDS Regulatory Compliance Committee	3/14/2022	3/14/2022
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	5/16/2022	3/14/2022
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	12/12/2023	12/12/2023
Updated Section III, Procedures to align with the OAR's and the CCO Contract Exhibit B, Part 9.	OHSU Health IDS Regulatory Compliance Committee	9/8/2025	9/8/2025
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	9/24/2025	9/8/2025

OHSU Health IDS, LLC		Policy & Procedure			
Company:	OHSU Health IDS, LLC	Committee Name:		Regulatory Compliance Committee	
Subject:	OHSU Health IDS Reporting Changes in Provider or Member Circumstances				
P&P Original Effective Date:	1/1/2020	P&P Origination Date:	1/1/2020	P&P Published Date:	1/1/2020
P&P Revision Effective Date:	1/1/2025	P&P Revision Published Date:		9/8/2025	
Reference Number:	COMP-120	Next Review Date:		9/2026	
Product (check all boxes applicable to this policy) <input type="checkbox"/> Dental <input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Pharmacy <input type="checkbox"/> Behavioral Health					

I. Policy Statement and Purpose

OHSU Health IDS will notify Health Share of Oregon within 10 days, regardless of whether OHSU Health IDS or a subcontractor is reporting the change, 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. OHSU Health IDS will provide such information to the Health Share Compliance and Delegation Oversight team via email: HearingsAndAppeals@healthshareoregon.org.

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.

II. Procedures

A. Notification of a Change in Provider’s Circumstance:

1. OHSU Health IDS will notify Health Share within 10 days when it receives information about a change in a network provider’s or subcontractor circumstances that may affect the network provider’s or subcontractor’s eligibility to provide services on behalf of OHSU Health IDS, including the termination of the provider agreement.
2. When the termination of a Participating Provider is for-cause, OHSU Health IDS shall notify Health Share within ten (10) days of terminating any Provider contract, including but not limited to the causes listed in Exhibit B, Part 4, and Section 5.k of the CCO Contract. OHSU Health IDS shall support and assist Health Share in giving the Administrative Notice Health Share is required to give to OHA’s Provider Enrollment Unit, as described in Exhibit B, Part 4, Section 5.k of the CCO Contract.

B. Notification of a Change in Enrollee’s Circumstances:

1. OHSU Health IDS will promptly notify Health Share when it 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
2. In these instances OHSU Health IDS staff will send an email to HearingsAndAppeals@healthshareoregon.org notifying them of the change in circumstance.

III. Related Policies & Procedures, Forms and References

Oregon Health Authority Health Plan Services Coordinated Care Organization Core Contract Exhibit B, Part 4, and Section 5.k
Health Share of Oregon 2022 Amended and Restated IDS Participation Contract

IV. Revision Activity

New P&P/Change/Revision and Rationale	Final Review/Approval	Approval Date	Effective Date of Policy/Change
New policy to be included in FWA Handbook per 2020 CCO contract. Created after feedback from initial submission. Policy will need to be approved by QIC after OHA approval		1/1/2020	1/1/2020
Changes made due to 2022 contract changes	OHSU Health IDS Regulatory Compliance Committee	3/14/2022	3/14/2022
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	5/16/2022	3/14/2022
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	12/12/2023	12/12/2023
Review only, no changes	OHSU Health IDS Regulatory Compliance Committee	9/8/2025	9/8/2025
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	9/24/2025	9/8/2025

OHSU Health IDS, LLC		Policy & Procedure			
Company:	OHSU Health IDS, LLC	Committee Name:	Regulatory Compliance		
Subject:	OHSU Health IDS Regulatory Compliance Committee				
P&P Original Effective Date:	11/1/2023	P&P Origination Date:	11/1/2023	P&P Published Date:	11/1/2023
P&P Previous Revision Effective Date:	1/1/2025	P&P Current Revision Published Date:		9/8/2025	
Reference Number:		Next Review Date:		9/2026	
Product (check all boxes applicable to this policy) <input type="checkbox"/> Dental <input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy <input type="checkbox"/> Behavioral Health					

I. Policy Statement and Purpose

- A. OHSU Health IDS will have a regulatory compliance committee which will be responsible for overseeing OHSU Health IDS's fraud, waste, and abuse prevention program and compliance with the terms and conditions of the OHA Health Plan Services Contract and the HealthShare of Oregon core contract.
- B. Members of the compliance committee include OHSU Health IDS's compliance officers and senior level management employees. The members of OHSU Health IDS's Regulatory Compliance Committee are:
 - 1. Nick Gross, OHSU Health IDS Chief Compliance Officer (Chair)
 - 2. Anju Kumar, OHSU Compliance Director (Co-Chair)
 - 3. Jeff Conklin, CEO OHSU Health IDS (Board Representation)
 - 4. Khalid Wahab, CAO OHSU Health IDS (Board Representation)
 - 5. Katrina McPherson, Chief Medical Officer (Board Representation)
 - 6. Sean Jessup, Vice President Medicaid and Medicare Programs (Board Representation)
 - 7. Kayla Jones, Senior Manager, Medicaid Operations
 - 8. Julie Spiert, Operations Director
 - 9. Mina Zarnegin, Operations Supervisor

II. Definitions

NA

III. Procedures

- A. The OHSU Health IDS Regulatory Compliance Committee shall facilitate the Board of Directors' effective oversight of the organization's compliance program, engagement in compliance issues impacting the organization's Medicaid business, and provision of support and resources for the organization's Compliance Officer. The OHSU Health IDS Chief Compliance Officer will serve as chair of the committee. Responsibilities of the committee include:
 - 1. Verify, approve and facilitate as warranted, the organizations adoption and periodic review of a compliance plan that encompasses all required elements for the organization's Medicaid business, including overseeing OHSU Health IDS fraud waste and abuse program and compliance with terms of the contract.

2. Review OHSU Health IDS quarterly appeals and grievance log and grievance system analysis.
3. Ensure that the organization's compliance activities are supported by adequate staff and other resources.
4. Conduct periodic reviews of operational compliance metrics and risk assessment; receive and direct the organization's responses to regular and ad hoc reports from the compliance team.
5. Take other such action as are consistent with its purpose.
6. The Regulatory Compliance Committee shall meet no less frequently than once per quarter.

IV. Related Policies & Procedures, Forms and References

Related List

V. Affected Departments:

Department List

VI. References:

References List

VII. Revision Activity

New P&P/Change/Revision and Rationale	Final Review/Approval	Approval Date	Effective Date of Policy/Change
New Policy	OHSU Health IDS Compliance Committee	12/12/2023	11/1/2023
Review only, no changes	OHSU Health IDS Compliance Committee	9/8/2025	9/8/2025
Board oversight, consent agenda	OHSU Health IDS Board of Directors	9/24/2025	9/8/2025

OHSU Health IDS, LLC		Policy & Procedure			
Company:	OHSU Health IDS, LLC	Committee Name:	Regulatory Compliance		
Subject:	OHSU Health IDS Effective Lines of Communication				
P&P Original Effective Date:	11/1/2023	P&P Origination Date:	11/1/2023	P&P Published Date:	11/1/2023
P&P Previous Revision Effective Date:	12/1/2025	P&P Current Revision Published Date:		9/8/2025	
Reference Number:	COMP 124	Next Review Date:		9/2026	
Product (check all boxes applicable to this policy) <input type="checkbox"/> Dental <input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Pharmacy <input type="checkbox"/> Behavioral Health					

I. Policy Statement and Purpose

- A. OHSU Health IDS and its compliance officers, its delegates and subcontractors will maintain effective lines of communication between their compliance offices and other members of their workforce. Systems are in place that are designed to maintain effective lines of communication between the OHSU Health IDS compliance officer and its workforce and subcontractors. Steps are also taken to effectively communicate, periodically and in a practical manner the Code of Conduct, policies and procedures contained in this FWA Handbook to the board of directors, high-level personnel, OHSU Health IDS workforce members, and 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.

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.

- B. Examples of the ways that this communication may take place are:
1. Email
 2. Staff meetings
 3. Personal meetings with workforce members
 4. Newsletters
 5. PowerPoint presentations to affected departments/personnel
 6. OHSU Health IDS Regulatory Compliance committee
 7. OHSU Health IDS Board of Directors meeting
 8. EthicsPoint confidential compliance hotline

II. Definitions

NA

III. Procedures

IV. Related Policies & Procedures, Forms and References

Related List

V. Affected Departments:

Department List

VI. References:

References List

VII. Revision Activity

New P&P/Change/Revision and Rationale	Final Review/Approval	Approval Date	Effective Date of Policy/Change
New Policy	12/12/2023	12/12/2023	11/1/2023
Updated OHSU IDS to OHSU Health IDS for consistency.	OHSU Health IDS Compliance Committee	9/8/2025	9/8/2025
Board oversight, consent agenda	OHSU Health IDS Board of Directors	9/24/2025	9/8/2025

OHSU Health IDS, LLC		Policy & Procedure			
Company:	OHSU Health IDS, LLC	Committee Name:	Regulatory Compliance Committee		
Subject:	OHSU Health IDS Requirements for Performing PI Audits				
P&P Original Effective Date:	1/1/2025	P&P Origination Date:	1/1/2020	P&P Published Date:	1/1/2020
P&P Revision Effective Date:	1/1/2025	P&P Revision Published Date:	9/8/2025		
Reference Number:	COMP-125	Next Review Date:	9/2026		
Product (check all boxes applicable to this policy) <input type="checkbox"/> Dental <input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Pharmacy <input type="checkbox"/> Behavioral Health					

I. Policy Statement and Purpose

All PI Audits performed by OHSU Health IDS Will be opened within twenty (20) Business Days after OHSU Health IDS receives a written Notice of Potential At-Risk Overpayment from OPI or OHSU Health IDS is notified of a potential Overpayment by HealthShare, employee, Subcontractor, Provider, Member, or any other internal or external source. All PI Audits conducted by OHSU Health IDS will be comprised of all the tasks and activities identified below and at the close of the PI Audit a written final PI Audit final report is created.

The OHSU IDS process for determining when an onsite PI Audit of Participating Providers is to be performed is as follows: An initial desk audit is done to establish predication for continued investigation. Upon determination of reasonable cause to continue the probe, the initial documentation necessary for investigation is obtained. Because every case is different, no set procedure can be applied to all cases. Once the desk audit is completed the findings are assessed to substantiate the allegations and/or referral. If the allegations are substantiated in the desk audit phase, the case is moved to an on-site audit. There are certain triggering events that will prompt an on site PI Audit without an initial desk audit being performed. Those triggers include quality of care issues that could result in member harm and the risk that documents may be altered, created or destroyed.

II. Procedures

A. Each PI Audit will include the following

1. Validate or verify the following information about the billing and/or individual rendering Provider(s)
 - i. Provider names
 - ii. All applicable Provider Medicaid Identification Number(s) and all enrollment file data (e.g., Provider address(es), all practice location(s), and, as applicable for the Provider type, the TIN/SSN/EIN, NPI, and taxonomy codes);
 - iii. Member(s) name(s) and Medicaid ID number, as applicable;
 - iv. Oregon business registration status, legal business name, and, if applicable, assumed business name;
 - v. Exclusion status of Provider(s) (LEIE & SAM) and any person(s) with ownership or control interest (including all managing employees), as these terms are defined by 42 CFR 455.101;

- vi. Provider license(s) and billing and rendering provider(s), as applicable;
 - vii. Provider certification(s).
2. Collect information about the billing issues identified
 3. Select a PI Audit focus or question, including the billing code(s) selected for review
 4. Review all Encounter claims or a statistically valid sample of Encounter claims
 5. Review clinical or other financial records
 6. Identify Overpayment or other audit findings
 7. Outcome(s) of a Provider appeal of the audit findings
 8. Overpayment recovery, repayment plan, or other corrective action to prevent future Overpayments.
- B. Procedures outlining information required to be documented in each final PI Audit report:
1. The information gathered about the Provider in section II, A above
 2. The date range of the Encounter claims audited
 3. PI Audit focus or question, including the billing code(s) selected for review
 4. Summary table: Data mining and report on the universe and sample of Encounters audited; the clinical or financial records reviewed
 5. Referrals made by OHSU IDS to licensing boards or other state or federal regulatory entities.
 6. Summary of audit criteria applied and the resulting financial and other relevant findings
 7. Final Overpayment
 8. The outcome of any Provider appeal(s), as applicable
 9. Summary of Overpayments recovered, repayment plan, and other Provider corrective action(s) or education or both to prevent future Overpayments by OHSU Health IDS and the disposition of the PI Audit
 10. Other relevant audit findings as OHSU Health IDS deems necessary

OHSU IDS will review all PI Audit reports completed by subcontractors to ensure they meet the requirements above and are complete and accurate. Any PI Audit reports that do not meet the requirements will be sent back for correction prior to submission to OHA and HealthShare.

- C. Procedures for OHSU Health IDS to respond to a written request from OPI or HealthShare for additional information or Encounter Data about any PI Audit conducted by OHSU Health IDS:
1. OHSU Health IDS and its subcontractors will maintain records, including records of all PI Audits and investigations related to suspected Fraud, Waste, and Abuse or overpayments. The records must include the detail necessary to substantiate all actions taken and outcome(s) reached for each PI audit or investigation for the CCO Contract.
 2. Allow access to all PI Audit and investigation supporting documents, information, systems, and facilities in accordance with Exhibit B, Part 9, Section 18 and Exhibit D, Section 15 of the CCO Contract.
 3. OHSU IDS will not delegate its responsibility to respond to an OPI request for additional information or encounter data about a PI audit or investigation, to its subcontractors
 4. OHSU Health IDS must send a response to HealthShare **within three (3) business days** for any records maintained by OHSU Health IDS or any of its subcontractors.
 5. OHSU Health IDS will send to HealthShare copies of all PI Audit files, Encounter Data, and other PI Audit supporting documentation in any form and criteria used for the PI Audit

within eighteen (18) business days of a request as required by Exhibit B, Part 9, Section 20.

III. Related Policies & Procedures, Forms and References
CCO Contract Exhibit B, Part 9, Section 15

IV. Revision Activity

New P&P/Change/Revision and Rationale	Final Review/Approval	Approval Date	Effective Date of Policy/Change
New Policy		TBD	1/1/2025
<p>Section I, Added the process for determining when an onsite PI audit will be performed.</p> <p>Section II, Procedures B.5. – added the final PI audit report will contain any referrals made to licensing boards or state and federal entities.</p> <p>Added any PI audit report completed by a subcontractor not meeting the documentation requirements will be sent back for corrections before submitting to OHA and HSO.</p> <p>C.1. – added OHSU Health IDS and subcontractors will maintain all records of PI audits.</p> <p>C.3. – added OHSU Health IDS will not delegated the responsibility to respond to OPI for information to subcontractors.</p> <p>C.4. – updated OHSU will respond to HSO with three business days.</p> <p>C.5. – updated OHSU will send HOS copies of all PI audit files, encounter data, supporting documentation within eighteen business days.</p>	OHSU Health IDS Compliance Committee	9/8/2025	9/8/2025
Board oversight, consent agenda	OHSU Health IDS Board of Directors	9/24/2025	9/8/2025