Compliance Program Manual

Policies and Procedures

Approved by the Board Oversight Compliance Committee on
January 18, 2024

UMPQUA HEALTH | 3031 NE STEPHENS STREET| ROSEBURG, OR 97470

UMPQUA HEALTH

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Compliance Department Commitments

The Compliance Team will strive to operate and conduct itself with the following principles in mind:

- We are a resource for the individuals and organization we serve.
- We honor and understand mistakes, and desire to create an environment where we all can learn from them.
- We are mindful of organizational resources, including staff time.
- We engage to educate and support.
- We strive for honesty, transparency, and fairness.
- We welcome feedback and believe it is a necessity for continuous growth.
- We recognize that flexibility is imperative; we are not rigid in process and thinking.
- We will provide information in a clear and concise manner.

Introduction

Umpqua Health, LLC (collectively with its subsidiaries, "Umpqua Health") is committed to operating in strict compliance within the rules and regulations that govern the organization. Operating within a heavily regulated environment, compounded by the diversity of its business ventures, Umpqua Health recognizes the critical importance of prioritizing and cultivating a robust Compliance and Fraud, Waste, and Abuse (FWA) Prevention.

In order to secure the effectiveness of this program, Umpqua Health has developed this Compliance Program Manual, in conjunction with its Fraud, Waste, and Abuse Prevention Handbook (Fraud, Waste, and Abuse Prevention Handbook), to safeguard the following business interests:

- Umpqua Health Alliance (UHA): Douglas County's Coordinated Care Organization (CCO), a Medicaid Managed Care program.
- Umpqua Health Management (UHM): A management services company and a licensed worker leasing company, established by Umpqua Health, engaged in the business of administering health care benefits programs by providing services such as financial services, human resources, employee leasing, medical management, utilization review, care coordination, quality improvement activities, fraud prevention activities, data processing, claims payment, records maintenance, and other services.
- Umpqua Health – Newton Creek (UH-NC): A rural health clinic.
- Umpqua Health Network (UHN): A clinically integrated network established by Umpqua Health.
- P3/ATRIO: A Medicare Advantage Plan. Umpqua Health is a delegate for P3, who manages the ATRIO lives in Douglas County. Umpqua Health has a delegation agreement with P3 to perform a variety of functions on behalf of P3.

This Compliance Program Manual was developed in conjunction with the Fraud, Waste, and Abuse Prevention Handbook by Umpqua Health's Compliance Department, with approval from the Board Oversight Compliance Committee and Board of Directors. The Chief Compliance Officer is responsible for ensuring the Compliance and FWA Program is updated regularly and reviewed annually, or more often if needed, with material changes approved by the Board Oversight Compliance Committee and Board of Directors.

The Compliance Program Manual operates under the framework of the "Seven Fundamental Elements of an Effective Compliance Program," as identified by the U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG).

1. Implementing written policies, procedures, and standards of conduct.
2. Designating a compliance officer and compliance committee.

3. Conducting effective training and education.
4. Developing effective lines of communication.
5. Conducting internal monitoring and auditing.
6. Enforcing standards through well-publicized disciplinary guidelines.
7. Responding promptly to detected offenses and undertaking corrective action.

Additionally, Umpqua Health is mandated by many contractual, State, and Federal requirements to have a Compliance and FWA Prevention Program, including:

1. UHA Health Plan Services contract ("CCO contract") with the Oregon Health Authority: Exhibit B, Part 9, Section 1 - 18.
2. Oregon Administrated Rules (OAR): OARs 410-120-1510, 410-141-3520, and 410-141-3625.
3. Code of Federal Regulations (CFR): 42 CFR § 433.116, 42 CFR Part 438 (42 CFR §§§§ 438.214, 438.600 to 438.610, 438.808), 42 CFR Part 455 (42 CFR §§§ 455.20, 455.104 through 455.106) and 42 CFR § 1002.3.
4. CFR: 42 CFR §§ 422.503(b)(4)(vi)(A–G), 423.504(b)(4)(vi)(A–G).
5. Centers for Medicare and Medicaid Services' Managed Care Manual: Chapter 21 and Prescription Drug Benefit Manual, Chapter 9 – Compliance Program Guidelines, Section 50 – Elements of an Effective Compliance Program.
6. HHS-OIG's Compliance Program Guidance for Hospitals (February 1998), Office of Inspector General's Supplemental Compliance Program Guidance for Hospitals (January 2005).
7. Social Security Act 1902(a)(68)

This Compliance Program Manual, in conjunction with the Fraud, Waste, and Abuse Prevention Handbook, discusses the structure of Umpqua Health's Compliance and FWA Prevention Program and outlines how the organization meets the contractual obligations listed above. This Compliance Program Manual and the Fraud, Waste, and Abuse Prevention Handbook apply to all internal and external personnel.

Definitions

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Organization or OHA. This includes reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary costs to the Organization or OHA (42 Code of Federal Regulation (CFR) § 455.2 and Oregon Administrative Rules (OAR) 410-120-0000(1)).

Actual conflict of interest: (For purposes of the Conflict-Of-Interest Policy) Any action or any decision or recommendation by a person acting in a capacity as a public official, the effect of which would be to the private pecuniary benefit or detriment of the person or the person's relative or any business with which the person or a relative of the person is associated unless the pecuniary benefit or detriment arises out of circumstances described in subsection (13) of ORS 244.220.

Affiliate: A person or entity that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person or entity specified (CCO Contract, Exhibit A).

Agent: Any person who has been delegated the authority to obligate or act on behalf of a provider (42 CFR § 455.101).

Approver: A designated individual or group (e.g. Executive Team, a secondary committee) who has been assigned an approver security level within Policy Tech that allows for documents to be published upon completion of the approver level(s) cycle.

Archived Policy: A policy will be archived upon being merged within another policy or internal document where it's no longer active as a standalone policy. The policy is not retired but is deemed important for historical or compliance reason to be documented in a repository.

Cash equivalent: Items that can be converted to cash, or that are used like cash, such as a general purposes gift card that can be redeemed anywhere (e.g. Visa gift card) (81 FR 88393).

CCO Contract: Includes any predecessor CCO Contract or other similar contract between UHA and OHA.

Content Owner: An individual assigned oversight of document content within Policy Tech.

Contract: (For purposes of the conflict-of-interest policy) includes any Predecessor CCO Contract or other similar contract between Contractor and OHA.

Contractor: All UHA affiliates, assignees, subsidiaries, parent companies, successors, and transferees, and persons under common control with UHA; any officers, directors, partners, agents and employees of such persons; and all others acting or claiming to act on their behalf or in concert with them.

Control (including: Controlling, Controlled, Controlled by, and under common Control with): Possessing the direct or indirect power to manage a Person or set the Person's policies, whether by owning voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position or corporate office the Person holds. OHA shall presume that a Person controls another Person if the Person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10 percent or more of the voting securities of the other Person.

Corrective Action Plan (CAP): Formal request from the Compliance Department to the department lead and executive assigned for a plan to be designed and followed to address identified deficiencies within a specified amount of time. Start time begins from the date assigned.

Covered Persons: All Directors, Officers, Staff and Volunteers of Umpqua Health, LLC or any subsidiary, Independent Contractors, or Community Advisory Council (CAC) member.

Creation Date: Date when policy was first created.

Date Assigned: The date the Compliance Department provides the risk response assignment to the department lead. This is the start date for all risk response assignments.

Department Lead: Whomever oversees the department and is therefore assigned the overall responsibility of overseeing the risk response process to resolve the matter(s).

Directors: An Individual who has voting authority as a member of the Board of Directors of Umpqua Health, LLC or any of its subsidiaries.

Disclosing Entity: A Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent (42 CFR § 455.101).

Downstream entity: Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between Umpqua Health and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services (42 CFR § 422.2).

Entity: A single legal entity capable of entering a risk contract that covers coordinated care services with the state and conducting the business of a Coordinated Care Organization (CCO).

Executive Assigned: The executive who oversees the department lead and is charged with ultimate responsibility for the assigned risk response process remedying the issue(s).

External personnel: Individual contractors, subcontractors, network providers, agents, first tier, downstream, and related entities, and their workforce.

First tier entity: Any party that enters into a written arrangement, acceptable to CMS, with Umpqua Health to provide administrative services or health care services for a Medicare eligible individual (42 CFR § 422.2).

Fiscal Agent: A contractor that processes or pays vendor claims on behalf of the Medicaid agency (42 CFR § 455.101).

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable Federal or State law (OAR 410-120-0000(97)).

Health Insurance Portability and Accountability Act of 1996 (HIPAA): The federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information (OAR 410-120-0000).

High Risk Criteria: A subcontractor is considered high risk if the subcontractor:

1. Provides direct service to members or whose work directly impacts member care or treatment; or
2. Has had one or more formal review findings within the last three (3) years for which OHA UHA or both has required the subcontractor to undertake any corrective action; or
3. Both (1) and (2).

High Risk Delegated Work: Work delegated in the following capacities are deemed high risk by UHA:

1. Wraparound.
2. Intensive Care Coordination.
3. Adult and Youth Mental Health.
4. Mobile Crisis.
5. Case Management.
6. Dental Utilization Management
7. Grievances.

8. Appeals (UHA has final adjudication).
9. Nurse Triage & Health Advice/Information Services for Members.
10. Credentialing and Re-credentialing Activities
11. Non-Emergent Medical Transportation (NEMT)
12. NEMT Call Center & Transportation pertaining to Flexible Services.
13. Leasing of employees in order to staff and administer CCO work.

Immediate Family Member: Legal spouse, domestic partner, parent, guardian, sibling, child, aunt, uncle, grandchildren and grandparents, including foster, in-law, and step relationships.

Indirect Ownership Interest: An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity (42 CFR § 455.101).

Internal Personnel: All Umpqua Health employees, providers, contractors, volunteers, interns, Board members, and Committee members.

Low and Medium Risk Criteria: A subcontractor is considered low and medium risk if the subcontractor:

1. Does not perform direct services to members or whose work does not directly impact member care or treatment.
2. Does not have formal review findings within the last three (3) years for which OHA, UHA, or both have required the subcontractor to undertake any corrective action.

Low and Medium Risk Delegated Work:

1. Third Party Claim Administration.
2. Dental Network.
3. Provider Network.
4. NEMT Network Development.

Managed Care Entity (MCE): Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), Primary Care Case Management (PCCMs), and Health Information Organization (HIOs) (42 CFR § 455.101).

Managing Employee: A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency (42 CFR § 455.101).

Member: (For purposes of the Conflict-Of-Interest Policy) when capitalized, means the owners of Umpqua Health, LLC. The Members of Umpqua Health, LLC are Douglas County Individual Practice Association, Inc. and Mercy Medical Center, Inc.

Member of Household: (For purposes of the Conflict-Of-Interest Policy) Any person who resides with the Covered Person.

Nominal value: At least $15 per item or $75 in annual aggregate per patient/members.

Notice of Opportunity (Notice): A notification sent from Compliance Department to the department lead informing her/him of a low-risk deficiency that needs to be mitigated in a timely fashion.

Officers: Employed personnel who hold the position of Vice President, Chief, or higher.

OHA: Oregon Health Authority or Authority and Division.

Opportunity Plan (OP): Formal request from the Compliance Department to the department lead and executive assigned to provide a written plan addressing how the identified deficiencies will be mitigated as soon as possible.

Other Disclosing Entity: Any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes (42 CFR § 455.101):

- Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
- Any Medicare intermediary or carrier; and
- Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Participates: (For purposes of the conflict-of-interest policy) Actions of a Department of Human Services (DHS) or OHA employee, through decision, approval, disapproval, recommendation, the rendering of advice, investigation or otherwise in connection with the CCO Contract.

Person: Any individual, partnership, corporation, association, public or private entity. For purposes of this definition, a public entity means State and local agencies and any other governmental agency but excluding federal agencies, federal courts, and the State courts. See 42 CFR § 401.102. When the term "person" is used in the lower case, such term means an individual human being.

Personally and Substantially: (For purposes of the conflict-of-interest policy) To participate personally means to participate directly. It includes the direct and active supervision of the participation of a subordinate in the matter. To participate substantially means that the employee's involvement is of significance to the matter. Participation may be substantial even

though it is not determinative of the outcome of a particular matter. However, it requires more than official responsibility, knowledge, perfunctory involvement, or involvement on an administrative or peripheral issue. A finding of substantiality should be based not only on the effort devoted to a matter, but also on the importance of the effort. While a series of peripheral involvements may be insubstantial, the single act of approving or participating in a critical step may be substantial. Personal and substantial participation may occur when, for example, an employee participates through decision, approval, disapproval, recommendation, investigation or the rendering of advice in a particular matter (5 CFR § 2635.402(b)(4)).

Policy: A document that typically outlines on a high level, steps taken to satisfy a contractual, regulatory, or organizational requirement.

Policy Number: Naming convention of policies. First two letters of a department name, followed by a number (should be done in sequential order with other department policies).

Potential Conflict of Interest: (For purposes of the Conflict-of-Interest Policy) Any action or any decision or recommendation by a person acting in a capacity as a public official, the effect of which could be to the private pecuniary benefit or detriment of the person or the person's relative, or a business with which the person or the person's relative is associated, unless the pecuniary benefit or detriment arises out of the following:

1. An interest or membership in a particular business, industry, occupation or other class required by law as a prerequisite to the holding by the person of the office or position.
2. Any action in the person's official capacity which would affect to the same degree a class consisting of all inhabitants of the state, or a smaller class consisting of an industry, occupation or other group including one of which or in which the person, or the person's relative or business with which the person or the person's relative is associated, is a member or is engaged. Membership in or membership on the board of directors of a nonprofit corporation that is tax-exempt under section 501(c) of the Internal Revenue Code.

Program Integrity Audit and PI Audit: Means, but is not limited to, the review of Medicaid claims for suspicious aberrancies to establish evidence that fraud, waste, or abuse has occurred, is likely to occur, or whether actions of individuals or entities have the potential for resulting in an expenditure of Medicaid funds which is not intended under the provisions of the CCO Contract, State or Federal Medicaid regulations, and whether improper payment has occurred.

Protected Information: All forms of personally identifiable client, Member, patient, or Provider information that are made confidential or privileged by State and federal law, and thus are prohibited from disclosure. The types of records and information covered, and the federal and State laws that apply to this definition may include, but are not limited to, the following:

i. Personal health information as defined and protected under 42 USC §§ 1320d to 1320d-9, 45 CFR parts 160 to 164, ORS 192.553 to 192.581, and ORS 179.505 to ORS 179.507;
ii. Drug and alcohol records as defined and protected under 42 USC § 290dd-2, 42 CFR part 2, and ORS 430.399(6);
iii. Genetic information as defined and protected under ORS 192.531 to 192.549
iv. Communicable disease information as defined and protected under ORS 433.008 and ORS 433.045(4);
v. Medical assistance records as defined and protected under 42 USC § 1396a(a)(7), 42 CFR § 431.300 to 431.307, and ORS 413.175;
vi. Other personal information as defined and protected under ORS 646A.600 to 646A.628;
vii. Educational records protected under FERPA and those protected under the Individuals with Disabilities Education Act;
viii. Child welfare records, files, papers, and communications provided for under ORS 409.225;
ix. Child abuse reports protected under ORS 419B.035;
x. Abuse records of adults with developmental disabilities or mental illness provided for under ORS 430.763;
xi. Elder abuse records and reports and any compilation thereof in accordance with ORS 124.090;
xii. Data provided to or created by or at the direction of a peer review body as defined and protected under ORS 41.675; and
xiii. Privileged communications as set forth under ORS 40.225 through ORS 40.295.; and
xiv. Personally identifiable demographic information about Community Advisory Council (CAC) members in the Annual CAC Demographic Report, consistent with Exhibit K, Section 5, Paragraph d.

Related entity: Any entity that is related to Umpqua Health by common ownership or control and

1. Performs some of Umpqua Health's management functions under contract or delegation;
2. Furnishes services to Medicare enrollees under an oral or written agreement; or
3. Leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period (42 CFR § 422.2).

Related Party: (For purposes of the Conflict-Of-Interest Policy) is a person or entity who is related to a Covered Person as follows:

a. Spouse;
b. Parent, sibling, child, or grandchild, or spouse of any of the same; or
c. An entity in which the covered person or any of the others listed above own one percent (1%) of the beneficial interest.

Relationship: A director, officer, partner, subcontractor, a person with beneficial ownership of 5% or more of Umpqua Health, network provider or person with an employment, consulting, or other arrangement with Umpqua Health for the provision of items and services that are significant and material to Umpqua Health's obligations under its contract with OHA.

Relative: (For purposes of the Conflict-Of-Interest Policy) meets any of the following:

- The spouse, parent, stepparent, grandparent (great or great-great), child, sibling, stepsibling, grandchildren (great or great-great), son-in-law or daughter-in-law, father-in law, mother-in-law, aunt, uncle, great uncle, great aunt, niece, nephew, first cousin of the public official, CAC member, or candidate;
- The parent, stepparent, grandparent (great or great-great), child, sibling, stepsibling, grandchildren (great or great-great), son-in-law or daughter-in-law of the spouse, father-in law, mother-in-law, aunt, uncle, great uncle, great aunt, niece, nephew, first cousin of the public official, CAC member, or candidate;
- Any individual for whom the Covered Person has a legal support obligation;
- Any individual for whom the Covered Person provides benefits arising from the Covered Person's employment or from whom the Covered Person receives benefits arising from that individual's employment.
- Any individual from whom the Covered Person receives benefits arising from that individual's employment.

Retired Policy: A policy deemed no longer to be applicable to Umpqua Health based on State, Federal, or contractual obligation changes and/or, in some cases, internal practices.

Review Date: On policies prior to 2023. Date(s) of when a policy has been reviewed and no substantial changes, beyond the updating of the header, were necessary. Multiple dates can be listed to demonstrate revision history (e.g. 2/15/14, 1/1/16, etc.).

Reviewed Policy: A current policy that was looked over and no substantial changes were made, other than the appropriate edits to the policy's header.

Revised Date: Date(s) of when a policy has had revisions. Multiple dates can be listed to demonstrate revision history (e.g. 1/1/15, 6/1/15, 1/1/16, etc.).

Revised Policy: A current policy that has substantial changes made to it. Substantial changes include, but are not limited to, edits to the "Purpose," "Responsibility," "Definition," or "Procedures" sections.

Risk Impact: Is gauged by the level of physical injury or discomfort to patients or members; potential monetary losses (e.g., damages); degree of regulatory enforcement; magnitude of publicity; level of staff involved; and amount of company disruption or resources needed to remedy the matter.

Risk Response: Corrective action measures designed to strategically mitigate the issues causing or potentially causing regulatory or contractual infractions.

Secretary: Secretary of State

Staff: Employees or contractors of Umpqua Health, LLC, or a related subsidiary.

Standard Operating Procedure (SOP): A set of formalized step-by-step instructions to aid staff in conducting internal complex routine operations.

Subcontract: Is either (i) a contract between UHA and subcontractor to which such subcontractor is obligated to perform certain work that is otherwise required to be performed by UHA, or (ii) is the infinitive form of the verb "to subcontract", i.e. the act of delegating or otherwise assigning certain work required to be performed by UHA under the CCO Contract to a subcontractor (CCO Contract, Exhibit A).

Subcontractor: An individual, agency, or organization to which disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients or members; or with which fiscal agent has entered into a contract agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement (42 CFR § 455.101).

Supplier: An individual, agency, or organization from which Umpqua Health or UHA purchases goods and services used in carrying out its responsibilities under Medicaid (42 CFR § 455.101).

Timely Subcontractor Performance Review: Subcontractor Performance Reviews are considered timely when conducted in accordance with the following schedule.

1. A high-risk subcontractor must be reviewed at least annually.
2. A low or medium risk subcontractor must be reviewed at least every three (3) years.

Vendors: Individual contractors, subcontractors, network providers, agents, suppliers, manufacturers, and any other alike entity.

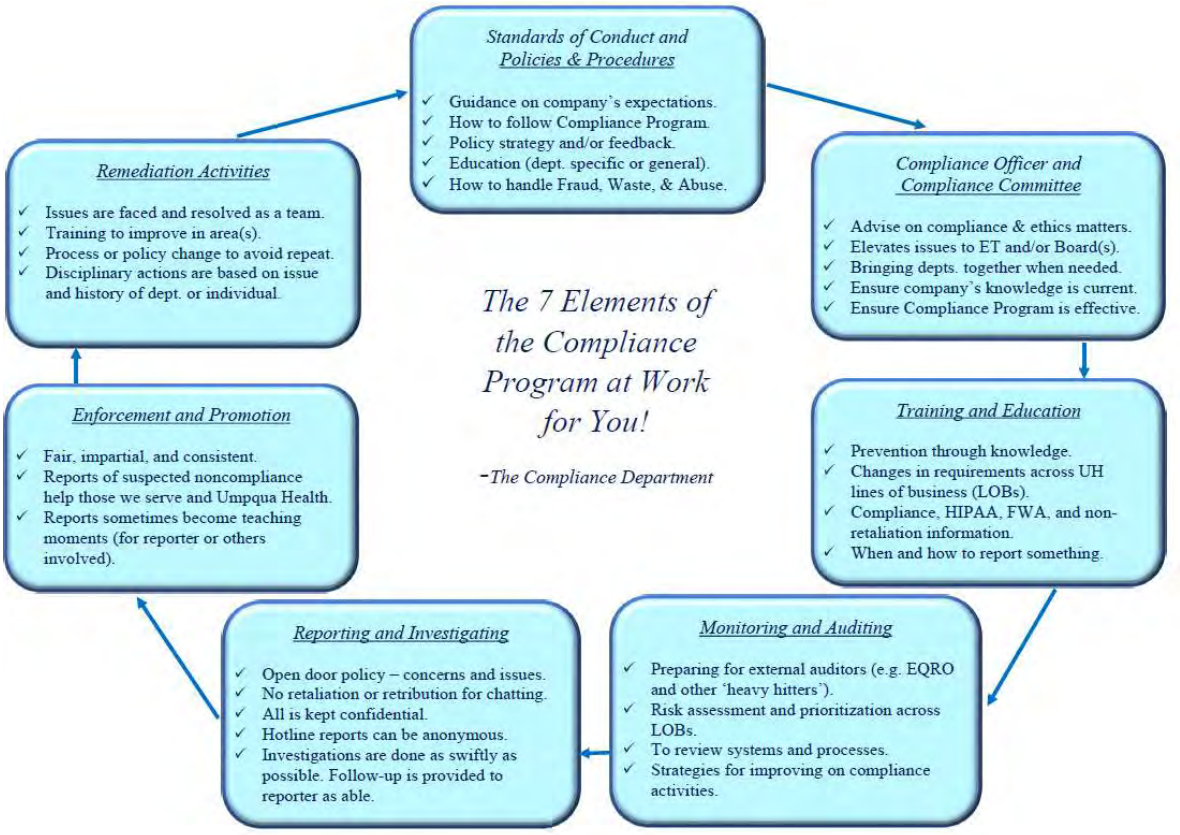
Version: Denotes the number of times a policy has been reviewed and/or revised.

Volunteer: An individual who performs hours of services for Umpqua Health, LLC or a related entity, without promise, expectation, or receipt of compensation for the services rendered. Members of the Community Advisory Council (CAC) are classified as Volunteers.

Waste: Overutilization or inappropriate utilization of services and misuse of resources, which is not typically criminal or intentional in nature.

Workflows: An internal department document that outlines the specific steps taken to meet a policy.

The Seven Elements of Umpqua Health's Compliance Program



Standards of Conduct

Code of Conduct and Ethics

The Umpqua Health Code of Conduct and Ethics Policy and its corresponding standalone document Code of Conduct (stands as a cornerstone of Umpqua Health's Compliance and FWA Prevention Program. The Board Oversight Compliance Committee, along with the Board of Directors, conduct an annual review of the Code of Conduct and Ethics to confirm it meets the current needs of the organization. It establishes the framework and expectations for ethical and compliant behavior among Umpqua Health's internal and external personnel.

Umpqua Health engages in contractual agreements with a multitude of individuals, providers, and subcontractors to support its organizational functions. Umpqua Health requires all internal and external personnel to commit to adherence of the organization's Code of Conduct and Ethics and corresponding policy. Internal Umpqua Health staff are provided a copy of the Code of Conduct and Ethics upon hire and subsequently on an annual basis and are expected to review and attest to comply. External individuals and entities typically receive a copy of the Code of Conduct and Ethics upon entering a contract with Umpqua Health and on an annual basis thereafter. Umpqua Health has made its Code of Conduct available on its website. Umpqua Health maintains a zero-tolerance policy for any conduct that is unlawful, unethical, or inconsistent with its established Code of Conduct and Ethics.

Internal and external personnel are expected to minimize potential conflicts of interest. In instances where conflicts of interest do arise, individuals and entities are required to promptly disclose these conflicts to Umpqua Health's Compliance Department. The Compliance Department will collaborate with Umpqua Health's Board Oversight Compliance Committee and Board of Directors to implement measures aimed at mitigating such conflicts when involving board members, external personnel, CAC members, and executive team members. The Compliance Officer will implement measures aimed at mitigating such conflicts for internal personnel.

RESPONSIBILITY

All Umpqua Health internal and external personnel

PROCEDURES

Internal Personnel

1. All Umpqua Health's internal personnel will receive a copy of the Code of Conduct and Ethics upon hire.
2. Newly hired internal personnel will be expected to review and attest to comply with Umpqua Health's Code of Conduct and Ethics program.
3. Annually, all internal personnel will be required to review and attest to comply with the Code of Conduct and Ethics program.

4. Any actions by internal personnel that contradict the expectations set out by the Code of Conduct and Ethics program may result in disciplinary actions, up to termination.

External Personnel

1. During the onboarding process of external personnel, Umpqua Health will supply a copy of its Code of Conduct and Ethics document.
2. External personnel will be required to review and attest to comply with the Code of Conduct and Ethics program.
3. Annually, external personnel will be required to review and attest to comply with the Code of Conduct and Ethics document.
4. Any actions by external personnel that go against Umpqua Health's Code of Conduct and Ethics program will result in sanctions up to and including termination of the contractual relationship.

Annual Review of Code of Conduct and Ethics

1. Annually, the Compliance Department will be tasked with updating and reviewing the Code of Conduct and Ethics document.
2. Revisions will be required to be approved by Umpqua Health's Board Oversight Compliance Committee and the entire Board of Directors.

Policies and Procedures

Umpqua Health is governed by many regulatory, contractual, and organizational requirements. Umpqua Health's policies and procedures play a fundamental part in supporting the foundation of the Compliance and FWA Prevention Program. Policies and procedures provide the detailed information for Umpqua Health's internal and external personnel to meet the requirements that govern the organization and demonstrate its commitment to satisfy those requirements (CO25 – Policies and Workflows – Drafting and Distribution). Policies are provided to internal and external personnel through Umpqua Health's internal policy management system, its employee handbook, provider handbook, Umpqua Health's website, and through distribution of the actual policies to impacted individuals and organizations. The organization's policies and procedures, policy manuals or handbooks intend to demonstrate Umpqua Health's commitment to comply with applicable State and Federal regulations, including Fraud, Waste and Abuse (FWA) laws, and privacy and security laws (e.g. Health Insurance Portability and Accountability Act (HIPAA) and HITECH).

Conflict of Interest and Safeguards

It is the policy of Umpqua Health that:

1. Each of Umpqua Health's Directors, Officers, Staff and Volunteers acts at all times in a manner that is consistent with Umpqua Health's purpose and exercises care to not act in a manner that places his or her private interests over Umpqua Health's interests; and
2. Each of Umpqua Health's Directors, Officers, Staff and Volunteers report to Umpqua Health's Compliance Officer any potential or actual conflict of interest. If a conflict of interest cannot be avoided, the conflict of interest will be managed in the best interests of Umpqua Health.

This Policy: (1) covers all Directors, Officers, Staff, and Volunteers, of Umpqua Health, LLC or any subsidiary, or Community Advisory Council (CAC) member ("Covered Persons"); (2) is intended to supplement, but not replace, any applicable state laws governing conflicts of interest applicable to Umpqua Health; and (3) addresses conflict of interest safeguards required under Umpqua Health's Coordinated Care Organization (CCO) Contract between UHA and the OHA ("CCO Contract"). The Board of Directors of Umpqua Health Alliance, LLC (the "Board") intends to re-evaluate this policy every January.

The purpose of this policy is to protect the interests of Umpqua Health in circumstances that may result in a divergence or conflict between the personal or business interests of a Covered Person and those of Umpqua Health. The Board recognizes that conflicts of interest are inevitable when a company as large and complex as Umpqua Health operates in a small community. That is particularly the case when physicians who have ownership interests in a Member (see definition) or are employed in some capacity by a Member (or employed in some capacity by a direct or indirect subsidiary of a Member, other than Umpqua Health), also serve Umpqua Health in some capacity. The Board has adopted this policy to help monitor and manage conflicts of interest so that they do not adversely affect Umpqua Health.

RESPONSIBILITY

It is the responsibility of all Directors, Officers, Independent Contractors, Staff and Volunteers of Umpqua Health, LLC or any subsidiary or CAC member to comply with this policy.

PROCEDURES

Overriding Duty to Umpqua Health

1. When acting in their official or unofficial capacities as Directors, Officers, Staff or Volunteers of Umpqua Health, all Covered Persons must in all ways and at all times act in Umpqua Health's best interests.
2. Without limiting the scope of this Policy, Covered Persons acknowledge that they are required to act in the best interests of Umpqua Health, and not to further their personal interests if those interests conflict with the best interests of Umpqua Health, when making decisions as Directors, Officers, Staff or Volunteers of Umpqua Health.

Conflict-of-Interest

1. For the purposes of this Policy, a "conflict of interest" is an actual or potential divergence between the objective interests of (a) the relevant covered person or a "Related Party" (as defined under definitions) and (b) Umpqua Health, LLC or any subsidiary arising from:
    a. Substantial ownership of or other interests in, including employment, contractual or other rights as a creditor of, any person or entity doing business with or likely to do business with Umpqua Health, LLC or any subsidiary or has any financial interest related to SHARE Initiative and other SDOH-E Spending;
    b. Service as a Director, Officer, Staff, consultant, or in a similar position with any person or entity doing business with or likely to do business with, or competing or likely to compete with, Umpqua Health, LLC or any subsidiary;
    c. Direct transactions with Umpqua Health, LLC or any subsidiary:
    d. Business opportunities of a kind that Umpqua Health, LLC or any subsidiary has the ability to, and would reasonably be expected to, participate in; or
    e. Other facts creating or reflecting a significant actual or apparent conflict between the interests of the Covered Person and the interests of Umpqua Health, LLC or any subsidiary.

Excluded Transactions

1. Transactions in the ordinary course of business of Umpqua Health, LLC or any subsidiary involving: director compensation paid by Umpqua Health, payment of compensation of employees by Umpqua Health, or reimbursement of ordinary business expenses in accordance with policies generally applicable to employees and directors of Umpqua Health are not conflict of interest transactions subject to the reporting and other requirements of this Policy. Any questions regarding whether a transaction is an excluded transaction should be directed to the Compliance Officer.

Disclosure

1. Prior to starting their position, new Directors, Officers, Staff or Volunteers shall receive a copy of this Policy and complete and submit to the Compliance Officer a written form disclosing all of their conflicts of interest using the attached Disclosure Statement or a similar form.
2. Prior to starting their position, internal personnel shall disclose any secondary employment "moonlighting" in writing to their direct manager and Human Resources of any involvement in any way connected with any business in competition, or potential competition, with Umpqua Health (See Employee Handbook, Section Moonlighting).
3. At least once each calendar year, all Covered Persons shall receive a copy of this Policy and complete and submit to the Compliance Officer a written form disclosing all of their conflicts of interest using the attached Disclosure Statement or a similar form.

Review and Approval of Initial and Annual Disclosure for Directors and Officers

1. The Chair of the Board of Umpqua Health Alliance, LLC ("Chair") is responsible in facilitating the review with the Board all annual disclosures submitted by all Directors and Officers of Umpqua Health, LLC or any subsidiary.
2. Upon receipt of a disclosed conflict by a Director or Officer, the Chair shall bring the matter to the Compliance Committee of the Board for review.
    a. The Compliance Committee will gather all information needed for the Board to evaluate the conflict, including the impact to the organization, and whether the conflict can be appropriately mitigated.
3. The Compliance Committee will make necessary inquires to develop an associated mitigation plan. When determining the feasibility and appropriateness of a mitigation plan, the Compliance Committee will review any disclosures with the following principles in mind:
    a. Fair market value
    b. Duration
    c. Perception
    d. Commercial Reasonableness
    e. Alternative options
4. The Compliance Committee shall then make any appropriate inquiries; acknowledge each conflict of interest and transaction that involves a conflict of interest; and develop a mitigation plan that it deems necessary with respect to any conflict of interest or transaction that involves a conflict of interest.

5. Upon completion of a mitigation plan, the Chair will present the conflict of interest and associated mitigation plan to the Board. The Board is expected to make appropriate inquiries into the conflict to determine whether the standards can be maintained as indicated earlier.
6. The annual disclosures shall be maintained in the records of Umpqua Health, LLC, but neither attached to the minutes nor made available to persons other than the Board and Officers of Umpqua Health, LLC without good cause.

Review and Approval of Initial and Annual Disclosure for Staff and Volunteers

1. For Staff and Volunteers, the Compliance Officer shall review all other annual disclosures submitted by the remaining Covered Persons (e.g. Staff, Volunteers) and make any necessary recommendations to mitigate any conflicts of interest.
2. The Compliance Officer will be responsible in reviewing and approving all Staff and Volunteers' conflict of interest disclosures and identifying and implementing any associated mitigation plans.
    a. The Compliance Officer will present to the Compliance Committee of the Board any Staff and Volunteers' conflicts of interest, along with the mitigation plan, for review.

Review and Approval of Specific Disclosures by the Board

1. If not previously disclosed in an annual disclosure described above, any Covered Person with an actual or potential conflict of interest with Umpqua Health, LLC or any subsidiary shall notify the Compliance Officer promptly in writing of the material facts of the actual or potential conflict of interest.
2. Covered Persons are encouraged to report to the Compliance Officer facts indicating an actual or potential conflict of interest of any other Covered Person with Umpqua Health, LLC or any subsidiary at any appropriate time.
3. For Directors and Officers, the Compliance Officer shall notify the Chair of any actual or potential conflicts of interest reported to the Compliance Officer.
    a. The Chair shall review with the Compliance Committee, as discussed earlier, the specific disclosures submitted by the Director or Officer. The Compliance Committee shall then make any appropriate inquiries; acknowledge each conflict of interest and transaction that involves a conflict of interest; and take any action it deems necessary with respect to any conflict of interest or transaction that involves a conflict of interest.

b. The Chair will then present the conflict of interest and the mitigation plan to the Board. The Board shall then make any appropriate inquiries; acknowledge each conflict of interest and transaction that involves a conflict of interest; and take any action it deems necessary with respect to any conflict of interest or transaction that involves a conflict of interest.

4. For Staff and Volunteers, the Compliance Officer shall review all other specific disclosures submitted by the remaining Covered Persons and make any necessary recommendations to mitigate any conflicts of interest. The Compliance Officer will present to the Compliance Committee any Staff and Volunteers' conflicts of interest, along with the mitigation plan, for approval.
5. Specific disclosures shall be maintained in the records of Umpqua Health, LLC, but neither attached to the minutes nor made available to persons other than the Board and executive officers of Umpqua Health, LLC without good cause.

Corporate Opportunities

1. Covered Persons shall disclose to the Compliance Officer any business opportunity that is or might be consistent with the activities of Umpqua Health, LLC or any subsidiary. Upon rejection of any business opportunity by the Board of Umpqua Health, LLC, any Covered Person may take advantage of that opportunity.

Abstention

1. When discussing any action during a Board meeting, any member of the Board who has a conflict of interest bearing directly on the action being discussed shall fully disclose or re-disclose the conflict of interest. Once the conflict of interest has been disclosed and the Board has had an opportunity to question the board member regarding the conflict of interest, such board member shall, if requested by the Board or by a majority of the members of the Board who do not have a conflict of interest with respect to such action, recuse himself or herself from the meeting (or the applicable portion thereof), take no further part in the debate regarding the action, and/or refrain from voting on the action. Covered Persons may not, on behalf of Umpqua Health, LLC or any subsidiary, enter into transactions in which they have a conflict of interest unless the transaction is approved in advance by the Board.

Conflict of Interest Transactions

1. As a general rule and whenever possible, Umpqua Health will seek to avoid engaging in any transactions or business opportunities in which a Director or Officer has a conflict of

interest. Before engaging in such a transaction, a majority of all non-conflicted members of the Board must approve the transaction after assessing the following standards on the record:

a. Can the service or product be offered by another organization or individual where there is no conflict of interest with similar quality and cost?
b. Will the transaction unfairly benefit a Covered Person?
c. Are the services or products necessary and commercially reasonable?
d. Are the terms of the transaction including the compensation to be paid fair and reasonable, established through a third party?
e. Is the transaction in the best interest of Umpqua Health, LLC and its subsidiaries?
f. Even if the transaction is fair and reasonable, will the transaction cause there to be an appearance of impropriety that cannot be mitigated?

2. Before approving a transaction involving a conflict of interest, the Board will require the following:
    a. Agreement in writing signed by the parties.
        i. Limited duration of no more than one year. Agreements can be extended for one-year terms only after Board approval and evaluation using the criteria above.
        ii. Detailed scope of work.
    b. Fair market value assessment. A conflict-of-interest transaction will be reviewed annually to determine if the transaction continues to meet fair market value standards, through a third-party appraiser. Written documentation shall be maintained demonstrating the evidence that the transaction was fair market value.
    c. Mitigation plan. The Board will document any additional mitigation steps that must be taken to protect Umpqua Health's interests. For example, if the transaction involves an Officer's relative, the Board might direct that the Officer not be involved in evaluating the relative's work and that the senior staff charged with responsibility report directly to the Board.

<u>Nepotism</u>

1. The Board recognizes that familial and similar relationships can both present risks and provide a tie to the community that aids in recruiting and otherwise provide value to Umpqua Health. Accordingly, employees of Umpqua Health, LLC or any subsidiary shall be hired, promoted, and otherwise dealt with solely on their qualifications and performance without either undue advantage or discrimination based upon his or her relationship with a Director, Officer, or employee of Umpqua Health, LLC or any

subsidiary. To the extent reasonably practical, no Officer or Staff of Umpqua Health, LLC or any subsidiary shall directly supervise his or her (a) spouse or former spouse; (b) sibling, parent, child, or grandchild; or (c) person of equal relationship to those set out in the preceding phrase created by marriage to any person. No employee of Umpqua Health, LLC or any subsidiary shall be directly involved in any decision to hire, promote, discharge, or demote any person listed immediately above.

Conflict-of-Interest Safeguards (CCO Contract Exhibit E, Section 17)

1. Offers, Promises, Etc.
    a. Umpqua Health Alliance (UHA) shall not offer, promise, or engage in discussions regarding future employment or business opportunity with any DHS or OHA employee (or relative or member of their household). Likewise, no DHS or OHA employee shall solicit, accept or engage in discussions regarding future employment or business opportunity, if such DHS or OHA employee participated personally and substantially in the procurement or administration of the CCO Contract as a DHS or OHA employee.
    b. UHA shall not offer, give, or promise to offer or give to any DHS or OHA employee (or any relative or member of their household), and such employees shall not accept, demand, solicit, or receive any gift or gifts with an aggregate value in excess of $50 during a calendar year or any gift (ORS 244.020, OAR 119-005-0001 to 199-005-0030) of payment of expenses for entertainment.
2. Interactions with Current or Former DHS or OHA Employees.
    a. Prior to the award of any replacement contract, UHA shall not solicit or obtain, from any DHS or OHA employee, and no DHS or OHA employee may disclose, proprietary or source selection information regarding such procurement, except as expressly authorized by the Director of DHS or OHA.
    b. UHA shall not retain a former DHS or OHA employee to make any communication with or appearance before OHA on behalf of UHA in connection with its CCO Contract if that person participated personally and substantially in the procurement or administration of the contract as a DHS or OHA employee.
    c. If a former DHS or OHA employee authorized or had significant role in the CCO Contract, UHA shall not hire such a person in a position having direct, beneficial, financial interest in the contract during the two (2) year period following that person's termination from DHS or OHA.

3. Documentation
    a. UHA shall maintain and update, as appropriate, the Conflict of Interest and Safeguard Handbook Policy in accordance with its policy CO25 – Policies and Workflows – Drafting and Distribution.
    b. To avoid actual or potential conflict of interest involving UHA members, DHS, or OHA employees and subcontractors the following safeguards are to be followed:
        i. UHA shall not disclose applications, bids, proposal information, or source selection information; and
        ii. UHA will:
            1. Promptly, within seven (7) business days after impermissible contact, any contact with UHA, bidder, or offeror in writing via Administrative Notice to OHA's Contract Administrator; and
            2. Reject any offer or proposed offer of employment; or disqualify itself from further personal and substantial participation in the procurement if UHA contracts or is contracted by a person who is a contractor, bidder, or offeror in a procurement involving federal funds regarding possible employment for UHA.
        iii. Additionally, UHA employs the following policies and procedures to address conflicts of interests:
            1. See section: Disclosure of Ownership and Control
            2. See section: Disclosures Pertaining to Business Transactions
            3. See section: Changes in Disclosures of Ownership Requiring OHA Pre-Approval
            4. See section: Disclosure of Information Regarding Crime Convictions
4. Reporting
    a. For the purposes of audits or inspections, UHA shall provide the Conflict of Interest and Safeguard Handbook Policy to OHA within five (5) business days of OHA's request or at the request of:
        i. The Oregon Secretary of State;
        ii. The Office of Inspector General (OIG);
        iii. The federal Government of Accountability Office;
        iv. Center for Medicare and Medicaid Services (CMS); or
        v. Any other authorized state or federal reviewers.
    b. The agencies listed above shall have the right to review and approve or disapprove this Conflict-of-Interest Safeguard Policy for compliance with CCO

Contract Exhibit E, Section 17. The findings of this review shall be provided to UHA within 30 days of receipt.

c. In the event OHA, or other entity, identifies deficiencies with the policy, UHA will remedy them using the process outlined in Exhibit D, Section 5 of the CCO Contract.

CONFLICT-OF-INTEREST DISCLOSURE STATEMENT FORM

Name: Click or tap here to enter text.

Title: Click or tap here to enter text.

Department: Click or tap here to enter text.

Pursuant to the Conflict-of-Interest Policy for directors, officers, staff and volunteers adopted by the Board of Directors of Umpqua Health Alliance, LLC, requiring disclosure of certain interests, a copy of which has been furnished to me, I hereby state that I or members of my immediate family have the following affiliation or interests and have taken part in the following transactions that, when considered in conjunction with my position with or in relation to Umpqua Health, LLC or any subsidiary, might possibly constitute a conflict of interest. (Check NONE where applicable.) (Attach a separate sheet, if necessary.)

Do you engage in secondary employment?

☐ Yes ☐ No

If yes, provide details of secondary employment including name of the organization, address and telephone number of the organization, nature of the role you perform, hours of involvement, how you are remunerated and the name of your direct supervisor.

Moonlighting Details:

Name, Address & Telephone Number of Secondary Employer:

_____

Job Title/Role: _____

Form of Compensation (Hourly, Salary, Alternative):_____

Direct Supervisor: _____

Description of Responsibilities: _____

_____

_____

Time commitment (How many hours per week do you dedicate to your secondary employment?): _____

Was your secondary employment disclosed during the interview and/or onboarding process and was prior approval obtained?

☐ Yes ☐ No

If yes, name of authorizer: _____

Describe how your secondary employment could potentially conflict with your responsibilities at Umpqua Health, LLC or any subsidiary:

_____

_____

_____By initialing, I acknowledge that I have disclosed my secondary employment and potential conflicts of interest arising from it. I understand my obligations to ensure that my secondary work does not interfere with my primary job duties or compromise the interests of Umpqua Health, LLC or any subsidiary.

Relationships with Vendors, Competitors or Other Outside Interests: Identify the relationships other than investment, of yourself or your immediate family, as described in the Conflict-of-Interest Policy.

( ) NONE

☐ You

☐ Name of Relative(s):

_____

Financial Interests or Investments: List and describe, with respect to yourself or your immediate family, all investments or other material financial interests as defined in the Conflict-of-Interest Policy.

( ) NONE

☐ You

☐ Name of Relative(s):

_____

Corporate Opportunity: Identify any business opportunities, including employment or contractual relationship involving yourself or your immediate family which might be considered a corporate opportunity as defined in the Conflict-of-Interest Policy.

( ) NONE

☐ You

☐ Name of Relative(s):

Gifts, Gratuities, and Entertainment: List and describe, with respect to yourself or your immediate family, all gifts, gratuities, loans, etc. as described in the Conflict-of-Interest Policy.

( ) NONE

☐ You

☐ Name of Relative(s):

Other Possible Conflicts: List and describe, with respect to yourself or your immediate family, any other circumstances which you believe could be considered a possible conflict of interest.

( ) NONE

☐ You

☐ Name of Relative(s):

Disclosure of Confidential or Inside Information: By signature below, I certify that neither I, nor any member of my immediate family, has disclosed confidential or inside information relating to the business of Umpqua Health, LLC or any subsidiary and/or used such information for the personal profit or advantage of myself, any member of my immediate family, or any entity of which I serve as an employee, officer, director or shareholder.

I hereby agree to report to the Compliance Officer (as set forth in the Policy) any change in the responses to any of the foregoing questions which may result from changes in circumstances before completion of my next Conflict-of-Interest Disclosure Statement.

I also hereby affirm the following:

1. I have received a copy of the Conflict-of-Interest Policy,
2. I have read and understand the Policy, and
3. I agree to comply with the Policy.

Signed: _____

Printed Name: _____

Date: _____

Receiving and Giving Gifts & Gratuities

To ensure transparency and mitigate conflict of interests, Umpqua Health generally discourages its internal personnel from soliciting or accepting any personal gift, gratuity, offer, favor, or entertainment directly or indirectly from a member, patient or an entity that Umpqua Health has a current or potential business relationship with.

The purpose of this policy is to outline the general process of receiving and giving items to patients, members, and/or vendors. The policy is a framework for internal personnel; however, not every situation may be as concrete. Internal personnel are encouraged to utilize his/her best judgement to minimize any perceived or actual conflict.

RESPONSIBILITY

All internal personnel.

PROCEDURES

Umpqua Health Newton Creek (UHNC) Patients and Umpqua Health Alliance (UHA) Members Gifts

1. Gifting items or any other form of remunerations (including waivers of copayments and deductible) to patients/members are prohibited, unless approved by the Compliance Department prior to the gifting.
    a. In the event approval is granted by the Compliance Department, items must be of nominal value (at least $15 per item or $75 in annual aggregate per patient/member) or fit within an exception granted by State and Federal regulations.
        i. Cash or cash equivalent is prohibited.
2. All gift and gratuities giving programs, including programs designed to promote health, which Umpqua Health directly or indirectly (e.g. Community Health Improvement Program) participates in, must be approved by the Compliance Department prior to initiating such program.
3. All gift and gratuities relating to service recovery efforts by UHNC intended to recover a dissatisfied patient by identifying and fixing the patient's concern brought forth. UHNC Patient Navigator or any UHNC staff may seek approval for service recovery from Chief Operating Officer or Clinic Manager.
    a. A monthly service recovery report must be submitted to the Compliance Department for tracking purposes.
        i. Items must be of nominal value (at least $15 per item or $75 in annual aggregate per patient/member) or fit within an exception granted by State and Federal regulations.

4. Generally speaking, Umpqua Health discourages its internal personnel from accepting gifts from members/patients due to the financial inequities as well as the impact to the provider-patient relationship.
    a. However, internal personnel should utilize his/her best judgement when accepting or declining a gift from patients/members.
        i. Cultural and relational perspective should be taken into consideration, as declining a gift may have an adverse impact in some situations.
    b. At no time, however, may staff accept a gift of cash or cash equivalent, nor accept any gift in-lieu of billing for or providing a service.

Vendors

1. Internal personnel are generally prohibited from personally accepting gifts, gratuities, entertainment from vendors.
    a. If internal personnel are personally presented with such items, they are to decline the items, if possible, citing this policy as the reason.
        i. In the event, internal personnel are unable to decline the item, the item must be reported and forfeited to the Compliance Department. The Compliance Department will make a determination on the disbursement of the item.
2. With regards to meals, internal personnel should utilize his/her best judgement when allowing a vendor to supply or pay for a meal.
    a. Example: The organization has a current relationship with a vendor, and the vendor would like to pay for a lunch meeting. This generally would be appropriate.
    b. Example: Umpqua Health is in the middle of a large procurement process, and a potential vendor would like to pay for a dinner. Allowing the potential vendor to pay for the meal would be discouraged. Umpqua Health should pay for its own meal in this scenario.
3. It is customary during certain times of the year in which vendors gift items to the organization (e.g., fruit basket during Christmas). Any item received must be reported to the Compliance Department for tracking purposes.
    a. For food items, internal personnel are free to accept the gift and share amongst their peers.
    b. If the item is non-food, including alcohol, the gift must be reported to the Compliance Department who will work with the Executive Team to determine

how the gift should be dispersed. Gifts should not be dispersed prior to informing the Compliance Department.

4. In the event Umpqua Health seeks to provide a gift or gratuity to a vendor, prior consent from the Compliance Department is required.

Government Authorities

1. UHA shall not offer, give, or promise to offer or give to any Department of Human Services (DHS) or OHA employee (or any relative or member of their household), and such employees will not accept, demand, solicit, or receive any gift or gifts with an aggregate value in excess of $50.00 during a calendar year or any gift ("Gift" for this purpose as defined by the Oregon Revised Statute (ORS) 244.020 and Oregon Administrative Rule (OAR) 199-005-0001 to 199-005-0030) of payment of expenses for entertainment as outlined in the Umpqua Health's Conflict-of-Interest Policy.

Oversight

1. Umpqua Health's Compliance Department is responsible for overseeing and administering this policy.
2. Any items that are accepted by the organization must be reported to the Compliance Department.
    a. The Compliance Department will track the gifts and gratuities received by the organization and report annually to the Board Oversight Compliance Committee of items gifted to and by the organization.
3. This policy is designed to provide a general framework; however, not all situations may be applicable. Staff should utilize his/her best judgment and consult with his/her supervisor and/or the Compliance Department when necessary. Any individual who intentionally deviates from this policy may receive disciplinary actions, up to and including termination.

Ownership Disclosures and Prohibited Affiliations

UHA, and its parent company Umpqua Health, are dedicated to ethical and transparent business practices and as such will seek pre-approval from OHA for certain changes in ownership as stipulated in the CCO Contract with OHA in Exhibit B, Part 8, Section 21.

Additionally, OHA, as contractually required via the CCO Contract with UHA must review the ownership and control disclosures submitted by UHA, its parent company, Umpqua Health, LLC, and any subcontractors as required by the Code of Federal Regulations (CFRs) in 42 CFR §§ 438.602(c) and 438.608(c). As such, Umpqua Health shall make disclosures required by Medicaid providers and fiscal agents as set forth in 42 CFR § 455.104.

To uphold program integrity and transparency in business relationships and to demonstrate how UHA will comply with CCO Contract Exhibit B, Part 8, Section 21 requiring pre-approval for certain changes in ownership, this policy serves to describe requirements of:

- Disclosure of ownership
- Disclosures pertaining to business transactions
- Disclosure of Ownership Requiring OHA Pre-Approval
- Prohibited Affiliations
- Disclosure of Information Regarding Crime Convictions

RESPONSIBILITY

Compliance Department
Executive Team
Provider Network

Disclosures of Ownership and Control

PROCEDURES

1. UHA will provide disclosures on information of ownership and control to OHA using the form provided by OHA as required by 42 CFR § 455.104(b) and CCO Contract, Exhibit B, Part 8, Sections 19, 20, and 21 on the following:
    a. The name and address of any person (individual or entity) with an ownership or control interest in UHA. The address will include as applicable, primary business address, every business location, and P.O. Box address.
    b. Date of birth and Social Security Number (in the case of an individual).

c. FEIN or other tax identification number (in the case of a corporation) with an ownership or control interest in UHA or in any subcontractor in which UHA has a 5 percent or more interest (≥5%).
d. Whether the person (individual or corporation) with an ownership or control interest in UHA is related to another person with ownership or control interest in UHA as a spouse, parent, step-parent, spouse's in laws, child, sibling, or step or half siblings; or whether the person (individual or entity) with an ownership or control interest in any subcontractor in which UHA has a 5 percent or more interest (≥5%) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
e. The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.
f. The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

2. Disclosures must be provided from provider, PCCMs, or disclosing entities at any of the following times:
    a. Upon the provider or disclosing entity submitting the provider application;
    b. Upon the provider or disclosing entity executing the provider agreement;
    c. Upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414; or
    d. Within 35 days after any change in ownership of the disclosing entity.
3. Disclosures from fiscal agents are due at any of the following times:
    a. Upon the fiscal agent submitting the proposal in accordance with the State's procurement process;
    b. Upon the fiscal agent executing the contract with the State;
    c. Upon renewal or extension of the contract; or
    d. Within 35 days after any change in ownership of the fiscal agent.
4. Disclosures from MCE (MCOs, PIHPs, PAHPs, and HIOs), except PCCMs are due at any of the following times:
    a. Upon the managed care entity submitting the proposal in accordance with the State's procurement process.
    b. Upon the managed care entity executing the contract with the State.
    c. Upon renewal or extension of the contract.
    d. Within 35 days after any change in ownership of the managed care entity.

5. All disclosures must be provided to OHA as the Medicaid agency using the form provided by OHA.
6. Consequences for failure to provide required disclosures:
    a. Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by 42 CFR § 455.104.

Disclosures Pertaining to Business Transactions

PROCEDURES

1. As a Medicaid provider for OHA, UHA agrees to furnish to OHA or to the Secretary on request, information related to business transactions.
2. Information must be submitted within 35 days of the date on a request by the Secretary or OHA. The information shall be full and complete to address:
    a. The ownership of any subcontractor with whom UHA has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
    b. Any significant business transactions between UHA and any wholly owned supplier, or between UHA and any subcontractor, during the 5-year period ending on the date of the request.
3. Denial of Federal financial participation (FFP).
    a. FFP is not available in expenditures for services furnished by UHA who fail to comply with a request made by the Secretary or OHA under item 2 of this policy or of 42 CFR § 420.205 (Medicare requirements for disclosure).
    b. FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or OHA and ending on the day before the date on which the information was supplied.

PROCEDURES

1. Change in control, without limiting the generality of the definition of "control" under the CCO Contract or the facts or circumstances that otherwise constitute a change in control of UHA, the following transactions will be presumed to involve a change in control:
    a. Consolidation or merger of UHA, or of a corporation or other entity or Person controlling or controlled by UHA, with or into a corporation or entity or Person,
    b. Any other reorganization or transaction or series of related transactions involving the transfer of more than 50% of the equity interest in UHA or more than 50% of the equity interest in a corporation or other entity or Person controlling or controlled by UHA,
    c. The acquisition by another of another of 10 percent (10%) or more of UHA's voting securities or the voting securities of any corporation or other legal entity that directly or indirectly controls UHA,
    d. The sale, conveyance or disposition of all or substantially all of the assets of UHA, or of a corporation or other entity or Person controlling or controlled by UHA, in a transaction or series of related transactions as specified in 42 CFR § 455.104(c)(3) and See section: Disclosures of Ownership and Control. Notwithstanding the foregoing, UHA shall have the right to apply to OHA for a determination that a particular transaction, on the facts and for the reason presented, will not result in a change in control (OAR 410-141-5405 and 410-141-5410) and therefore is not subject to prior written notice to and approval by OHA (OAR 410-141-5320 and 410-141-5325).
        i. UHA must also comply, as applicable, with OAR 409-070-0000 through 409-070-0085.
2. In the event a Person who has a controlling interest in UHA desires to give up their control, UHA shall provide OHA legal notice, in accordance with Exhibit D, Section 25(a) of the CCO Contract, at least 30 days prior to any change in ownership which will be deemed protected information under the CCO Contract until the transaction is concluded (OAR 410-141-5320).
    a. UHA shall reimburse OHA for all legal fees reasonably incurred by OHA in reviewing the proposed assignment or transfer and in negotiating and drafting appropriate documents.
3. UHA shall provide Administrative Notice, in accordance with Exhibit D, Section 25(b) of the CCO Contract, to OHA's Contract Administrator of any changes of address, and as

applicable licensure status as a health plan with Department of Consumer and Business Services or as a Medicare Advantage plan within 14 days of the change and for any change in Federal tax identification number (TIN) within 10 days of the date of change.

4. Failure to notify OHA of any of the above changes may result in a sanction from OHA and may require corrective action to correct payment records, as well as any other action required to correctly identify payments to the appropriate TIN.
5. UHA understands and agrees that UHA is the legal entity obligated under the CCO Contract and that OHA is engaging the expertise, experience, judgment, representations and warranties, and certifications of UHA set forth in the CCO Contract and in the application for the CCO Contract.
    a. UHA may not transfer, subcontract, assign or sell its contractual or ownership interests, such that UHA is no longer available to provide OHA with its expertise, experience, judgment and representations and certifications, without first obtaining OHA's prior written approval 120 days before the effective date of such transfer, subcontract, assignment or sale occurs, except as otherwise provided in Exhibit B, Part 4, Section 13 of the CCO Contract governing adjustments in service area or enrollment and Exhibit D, Section 19.
6. As a condition precedent to obtaining OHA's approval, UHA shall provide to OHA, via Administrative Notice, all of the following:
    a. The name(s) and address(es) of all directors, officers, partners, owners, or persons or entities with beneficial ownership interest of 5% or more (>5%) of the proposed new entity's equity;
    b. Representation and warranty signed and dated by both the proposed new entity and UHA that represents and warrants that the policies, procedures and processes issued by the UHA will be those policies, procedures, or processes provided to, and if required, approved by, OHA by UHA or by an existing contractor within the past two (2) years, and that those policies, procedures and processes still accurately describe those used at the time of the ownership change and will continue to be used by the new entity once OHA has approved the ownership change request, except as modified by ongoing contract and Oregon Administrative Rule (OAR) requirements.
        i. If UHA and the proposed new entity cannot provide representations and warranties required, OHA shall be provided with the new policies, procedures and processes proposed by the proposed new entity for review consistent with the requirements of the CCO Contract;

c. The financial responsibility and solvency information for the proposed new entity for OHA review consistent with the requirements of the CCO Contract; and
d. UHA's assignment and assumption agreement or such other form of agreement, assigning, transferring, subcontracting or selling its rights and responsibilities under the CCO Contract to the proposed new entity, including responsibility for all records and reporting, provision of services to members, payment of valid claims incurred for dates of services in which UHA has received a CCO payment, and such other tasks associated with termination of UHA's contractual obligations under the CCO Contract.

7. OHA may require UHA to provide such additional information or take such actions as may reasonably be required to assure full compliance with contract terms as a condition precedent to OHA's agreement to accept the assignment and assumption or other agreement.
8. OHA will review the information to determine that the proposed new entity may be certified to perform all of the obligations under the CCO Contract and that the new entity meets the financial solvency requirements and insurance requirements to assume the CCO Contract.

Prohibited Affiliations

PROCEDURES

UHA may not knowingly have a relationship with the type described in item 3 with any of the following:

a. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
b. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR § 2.101, of a person described in (1)(a) of this section.

2. UHA may not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.
3. The relationships described in item 1 above, are as follows:
    a. A director, officer, or partner of UHA.
    b. A subcontractor of UHA, as governed by § 438.230.
    c. A person with beneficial ownership of 5 percent or more (>5%) of UHA's equity.

   d. A network provider or person with an employment, consulting or other arrangement with UHA for the provision of items and services that are significant and material to UHA's obligations under its contract with the State.

4. If OHA finds that UHA is not in compliance with the previous sections of this policy, OHA:
   a. Must notify the Secretary of the noncompliance.
   b. May continue an existing agreement with UHA unless the Secretary directs otherwise.
   c. May not renew or otherwise extend the duration of an existing agreement with UHA unless the Secretary provides to OHA and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.
   d. Nothing in this policy must be construed to limit or otherwise affect any remedies available to the U.S. under sections 1128, 1128A or 1128B of the Act.
5. Consultation with the Inspector General will be done for any action by the Secretary described in items (4)(b) or (c) above.

Disclosure of Information Regarding Crime Convictions

PROCEDURES

1. Before OHA enters into or renews an agreement, or at any time upon written request by the OHA, UHA must disclose to OHA the identity of any person who:
    a. Has ownership or control interest in UHA, or is an agent or managing employee of UHA; and
    b. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX Services Program since the inception of those programs.
2. In the event UHA learns of any such disclosures OHA and the Health and Human Services Inspector General (HHS-OIG) must be notified within 20 working days from the date it receives the information.
3. Information pertaining to any actions taken on UHA's application for participation in the Medicaid program must also be communicated to HHS-OIG.
4. Denial or termination of provider participation.
    a. OHA may refuse to enter into or renew an agreement with UHA if any person who has an ownership or control interest in UHA, or who is an agent or managing employee of UHA, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services Program.
    b. OHA may refuse to enter into or may terminate UHA's agreement if it determines that UHA did not fully and accurately make any disclosure required under procedure 1 of this policy.

Chief Compliance Officer, Compliance Officer, Compliance Committee and Compliance Staff

Chief Compliance Officer

The Chief Compliance Officer reports to the Chief Executive Officer and UHA's Board of Directors.

UHA's Chief Compliance Officer is tasked with oversight and implementation of the Compliance and FWA Prevention Program. This includes developing and implementing written policies and procedures, as outlined in Paragraph B, Section 11 of Exhibit B, Part 9 of the CCO contract. Furthermore, the Chief Compliance Officer is responsible for creating the Annual Prevention Plan, as detailed in Exhibit B, Part 9, Section 12 of the CCO Contract.

UHA's Chief Compliance Officer is:

Nancy Rickenbach
Chief Compliance Officer
Umpqua Health, LLC.
3031 NE Stephens Street
Roseburg, Oregon 97470
Phone: (503) 830-3488
Email: nrickenbach@umpquahealth.com

Compliance Officer

UHA's Compliance Officer is responsible for the daily operations of the Compliance and FWA Prevention Program and plays a crucial role in promoting it. The Compliance Officer ensures that both internal and external personnel are informed about the program and aware of the resources available to them for maintaining compliance and preventing fraud, waste, and abuse.

The Compliance Officer reports to the Chief Compliance Officer and has direct access to the Chief Executive Officer, the UHA Board Oversight Compliance Committee and Board of Directors. The Compliance Officer provides compliance reports to UHA's Board of Directors, Board Oversight Compliance Committee, and the Chief Executive Officer quarterly, or more often as needed.

UHA's Compliance Officer is:

Jamie Smith-Reese, AHFI, CPC-P
Compliance Officer
Umpqua Health, LLC.
3031 NE Stephens Street
Roseburg, Oregon 97470
Phone: (541) 464-4984
Email: jsmithreese@umpquahealth.com

Compliance Committee

UHA has established a Board Oversight Compliance Committee (BOCC), which is a subcommittee of UHA's Board of Directors. The BOCC operates in accordance with its charter, dated October 11, 2023. This committee is responsible for overseeing the overall Compliance and FWA Prevention Program, ensuring it is operating effectively and is promptly reviewing and mitigating risks for the organization, with the terms and conditions of the Care Coordination Organization (CCO) Contract, Exhibit B, Part 9, Section 11 and (OAR) 410-141-5325.

The committee is designed to ensure the Compliance Officer has the necessary allocated resources to successfully execute the Compliance and FWA Prevention Program. The committee convenes at least once every quarter to assess the reports provided by the Compliance Officer, ensuring the effectiveness of the Compliance and FWA Prevention Program, and ensure the program meets or exceeds Health and Human Services' Office of Inspector General (HHS-OIG) Compliance Program Guidance.

Given the diverse nature of Umpqua Health's portfolio, it is imperative to maintain a versatile committee that can comprehensively assess risk within each line of business. The BOCC structure for Umpqua Health is as follows:

- **Board Chair**
  - Dr. Bart Bruns
- **Board Members**
  - Neal Brown
  - Tim Freeman, Commissioner
  - Jerry O'Sullivan
  - Russell Woolley
- **Umpqua Health Senior Level Management Staff**
  - Brent Eichman, Chief Executive Officer
  - Nancy Rickenbach, Chief Compliance and Chief Operating Officer
  - Keith Lowther, Chief Financial Officer
  - Jamie Smith-Reese, Compliance Officer

The purpose of the policy is to outline the Board Oversight Compliance Committee structure within the organization (Oregon Administrative Rule (OAR) 410-141-5325).

PROCEDURES

1. The BOCC is ultimately responsible for overseeing the Company's Compliance and FWA Prevention Program and compliance with the terms and conditions of the Care Coordination Organization (CCO) Contract. See Exhibit B, Part 9, Section 11 of the CCO Contract. Additionally, the BOCC will be responsible for ensuring that Umpqua Health's Compliance and FWA Prevention Program meets or exceeds Health and Human Services' Office of Inspector General (HHS-OIG) Compliance Program Guidance.
2. Participants of the BOCC include:
    a. At least three of CCO's directors; and
    b. At least one-third of the members of the committee must not be:
        i. Officers or employees of the CCO or of any entity that controls, is controlled by or is under common control with the CCO; or
        ii. Beneficial owners of a controlling interest in the voting securities of the CCO or of an entity that controls, is controlled by or is under common control with the CCO.
    c. Chief Executive Officer (participant, non-voting rights)
    d. Chief Compliance and Operating Officer (participant, non-voting rights)
    e. Chief Financial Officer (participant, non-voting rights)
    f. Compliance Officer (participant, non-voting rights)
    g. Other participants may be included on an ad hoc basis, specifically in scenarios where a subject matter expert is needed to discuss an issue.
3. The BOCC will operate in accordance with its charter, dated October 11, 2023.
4. The BOCC will meet quarterly; in which additional meetings may be called at the request of the Chair of the BOCC.
    a. Three voting members shall constitute a quorum, and at least one person who is not an officer or employee of the Company or of any entity that controls, is controlled by or is under common control with the Company.

Special Investigations Unit

The UHA Special Investigations Unit (SIU) is a branch of the Compliance Department and includes a team of employees dedicated to and responsible for implementing the Annual FWA Prevention Plan. The SIU team includes at least one professional employee (e.g. an investigator, attorney, paralegal, professional coder, or auditor) who reports directly to the Chief Compliance

Officer. UHA ensures its investigators meet mandatory core and specialized training program requirements, as well as training SIU staff to be knowledgeable about the provision of medical assistance under Title XIX of the Act and the operations of health care providers.

The SIU is tasked with fulfilling the FWA program integrity requirements of the CCO contract, responsible for investigating all reported incidents of fraud, waste and abuse and developing and implementing the FWA Prevention Program. The SIU also has access to individuals who have forensic or other specialized skills that support the investigation of cases through consultant agreements and other contractual arrangements.

The Special Investigations Unit, led by the Compliance Officer and supported by the Compliance Team, includes the following staff and positions:

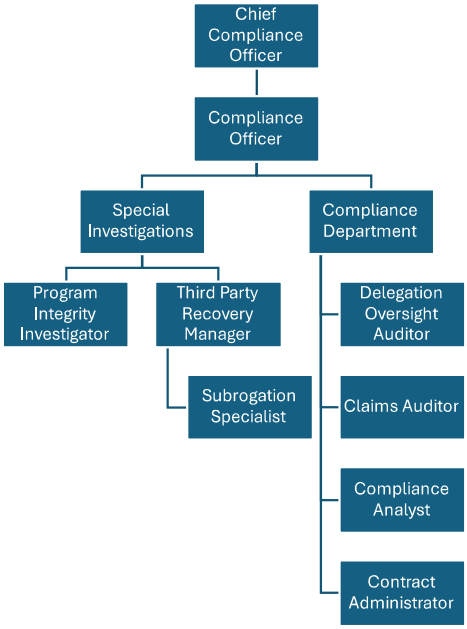
- Compliance Officer
- Program Integrity Investigator
- Third Party Recovery Manager
- Subrogation Recovery Specialist

Compliance Department

The Compliance Department is tasked with, and responsible for, implementing the Compliance and FWA Prevention Program. The Compliance Officer oversees the following Compliance Department staff:

- Compliance Auditor, Delegation Oversight
- Compliance Auditor, Claims
- Compliance Analyst
- Contract Administrator

Compliance Department



Training and Education

Umpqua Health considers training and education as a proactive strategy in combatting compliance issues. Umpqua Health is committed to ensuring that its internal and external personnel are appropriately and timely trained of the laws and regulations that govern the organization and are expected to actively engage with and comprehend the training and education they receive.

The purpose of the policy is to set expectations for completing compliance related trainings. The framework outlines the process for working through any potential situations where timely completion of trainings does not occur.

RESPONSIBILITY

All Umpqua Health internal and external personnel.

Internal Personnel: Umpqua Health conducts training for all personnel upon their initial hire and on an annual basis thereafter. Additional training details can be found in the work plan for the current contract year and Compliance Training Policy (see below).
Umpqua Health is committed to investing in and providing education, training and resources to enhance the knowledge, qualifications, and professional development of its Compliance Department personnel within their respective roles. Certain Compliance positions at Umpqua Health require that staff maintain specialized certifications and designations in areas such as FWA, coding, auditing, and compliance as a requirement of their employment. To support the training and education requirements of Compliance personnel, Umpqua Health offers opportunities to attend compliance and FWA conferences, seminars, and webinars, as well as training in coding, auditing and investigative techniques. Additionally, Compliance Department staff are trained to be knowledgeable about the operations of health care providers and the provision of medical assistance under Title XIX of the Act.

Umpqua Health also delivers specialized training to its internal staff, including the Compliance Officer. For example, credentialing staff receive annual training in accordance with CCO Contract Exhibit B, Part 9(11)(b)(8), covering topics such as exclusion screening (42 CFR § 438.608(b)) and prohibition of engaging excluded providers (42 CFR § 438.214(d)). Additionally, Umpqua Health offers additional training to ensure compliance with CCO contract requirements for internal personnel who do not fall under the purview of the Compliance Department, such as Cultural Competency training.

External Personnel: Umpqua Health mandates that external personnel undergo certain training sessions similar to those required for Umpqua Health's internal staff. Umpqua Health expects its external personnel will regularly complete training programs that satisfy State and Federal requirements, particularly in relation to FWA, Compliance, and HIPAA. Additionally, external

personnel responsible for delegated credentialing activities are also expected to complete training regarding exclusions.

Board of Directors: The Compliance Officer provides education to the Board of Directors to ensure Board members are aware of the compliance risks for the organization.

Compliance Training

PROCEDURES

Internal Personnel: Employees, Providers, Independent Contractors, and Volunteers

1. All new internal personnel are expected to complete assigned compliance training by the end of their first 30 days.
    a. Exceptions can be made with prior approval from the Human Resources and Compliance Department.
        i. Unless an exception is granted, all online trainings must be completed no later than 14 days of an individual's first day using the LMS training platform, and the New Hire Compliance Overview must be completed at first opportunity from date of hire.
    b. Assigned trainings include the following topics:
        i. Conflict of Interest.
        ii. Code of Conduct and Ethics.
        iii. Umpqua Health's Compliance Policy, False Claims Act and Whistleblower Protection
        iv. Oregon False Claims Act
        v. Compliance Program Manual
            1. This manual is available to internal staff on Umpqua Health's policy management platform, intranet, SharePoint, and is available to external staff on Umpqua Health's website.
        vi. UHA Fraud, Waste and Abuse Prevention Handbook
            1. This manual is available to internal staff on Umpqua Health's policy management platform, intranet, SharePoint, and is available to external staff on Umpqua Health's website.
        vii. Medicaid Reporting Requirements
        viii. CO19 – Disciplinary Process for Compliance Infractions
        ix. Health Insurance Portability and Accountability Act (HIPAA).
        x. HIPAA: Remote Access Training, as applicable (i.e. those with portably devices or VPN ability).

1. Staff training occurs if remote work or remote access becomes tied to job duties.

2. Exclusions and prohibited affiliation training (for new credentialing staff and management) is provided through review of the following section of the Compliance Program Manual.
    a. Disclosure of Ownership and Control (fka CO30 - Disclosure of Ownership and Control)
    b. Disclosures Pertaining to Business Transactions (fka CO31 - Disclosures Pertaining to Business Transactions)
    c. Prohibited Affiliations (fka CO33 - Prohibited Affiliations)
    d. Disclosure of Information Regarding Crime Convictions (fka CO34 - Disclosure of Information Regarding Crime Convictions)
3. Annually, internal personnel are expected to complete refresher trainings.
    a. These trainings are provided through the LMS training platform and must be completed by the required due date.
        i. Individuals are typically given at least 30 days to complete a required training.
        ii. FWA trainings must be completed within 365 days of the last completed training session.
    b. Exceptions will be made on a limited basis, as required by law (e.g. medical leave).
    c. Annual trainings include the following subjects:
        i. Conflict of Interest.
        ii. Code of Conduct and Ethics
        iii. Umpqua Health's Compliance Policy, False Claims Act and Whistleblower Protection
        iv. Oregon False Claims Act
        v. Compliance Program Manual
            1. This manual is available to internal staff on Umpqua Health's policy management platform and is available to external staff on Umpqua Health's website.
        vi. UHA Fraud, Waste and Abuse Prevention Handbook
            1. This manual is available to internal staff on Umpqua Health's policy management platform and is available to external staff on Umpqua Health's website.
        vii. Medicaid Reporting Requirements
        viii. CO19 – Disciplinary Process for Compliance Infractions

ix. Health Insurance Portability and Accountability Act (HIPAA).
x. HIPAA: Remote Access Training at Non-Regular Training Cycles, as applicable and annually (i.e. those with portable devices or VPN ability).
    1. Staff training occurs if remote work or remote access becomes tied to job duties.

4. Exclusions and prohibited affiliation training (for credentialing staff and management) is provided through review of the following section of the Compliance Program Manual.
    a. Disclosure of Ownership and Control (fka CO30 - Disclosure of Ownership and Control)
    b. Disclosures Pertaining to Business Transactions (fka CO31 - Disclosures Pertaining to Business Transactions)
    c. Prohibited Affiliations (fka CO33 - Prohibited Affiliations)
    d. Disclosure of Information Regarding Crime Convictions (fka CO34 - Disclosure of Information Regarding Crime Convictions)
5. Internal personnel who fail to complete a training by the required due date will be removed of his/her regular duties/schedule until the training is completed.
    a. Additionally, failure to complete trainings on time may result in disciplinary actions. Potential actions include:
        i. Verbal warning.
        ii. Written warning.
        iii. Suspension.
        iv. Termination.

<u>Internal Personnel: Provider Network Personnel</u>

1. Annually Provider Network personnel responsible for credentialing and subcontracting with third parties shall be trained and educated on material pertaining to as required (CCO Contract Exhibit B, Part 9, Section 11(b)(8)):
    a. Provider screening and enrollment requirements (42 CFR § 438.608(b)); and
    b. The prohibition of employing, subcontracting, or otherwise maintaining a relationship with sanctioned individuals or entities (42 CFR § 438.214(d)).
2. Staff annually review the following sections within the Compliance Program Manual:
    a. Disclosure of Ownership and Control (fka CO30 - Disclosure of Ownership and Control)
    b. Disclosures Pertaining to Business Transactions (fka CO31 - Disclosures Pertaining to Business Transactions)
    c. Prohibited Affiliations (fka CO33 - Prohibited Affiliations)

d. Disclosure of Information Regarding Crime Convictions (fka CO34 - Disclosure of Information Regarding Crime Convictions)

Internal Personnel: Board Members

1. Onboarding Training.
    a. Explanatory Welcome Letter and Compliance New Board Member Education packet containing:
        i. Items to review:
            1. Umpqua Health Compliance Program Manual
            2. Fraud, Waste, and Abuse Prevention Handbook.
            3. Umpqua Health's Code of Conduct.
            4. Practical Guidance for Health Care Boards on Compliance Oversight.
            5. Health and Human Service's Office of Inspector General (HHS-OIG) video, "Guidance for Health Care Boards."
            6. Fiduciary Responsibility PowerPoint.
            7. Fraud, Waste, and Abuse PowerPoint.
        ii. Items to return:
            1. New Board Member Compliance Training Attestation
            2. Board Member Information- Exclusion Database
            3. Conflict-of-Interest Disclosure Form
2. Annual Training.
    a. Fiduciary Responsibility.
    b. Fraud, Waste, and Abuse.
    c. Oregon False Claims Act.
    d. Medicaid Reporting Requirements.
    e. Conflict-of-Interest form completion.
3. Continual Training.
    a. Because board members are engaged in the review and voting upon material changes to the Umpqua Health Compliance and FWA Prevention Program and the Umpqua Health Code of Conduct whenever those changes may occur, annual trainings are not required (See sections: Code of Conduct and Ethics and Review of Compliance and FWA Prevention Program for review requirements).

External Personnel: Individual contractors, subcontractors, network providers, agents, first tier, downstream, and related entities, and their workforce.

As a condition to contracting, external personnel are required to complete certain trainings in order for Umpqua Health to meet contractual and regulatory requirements.

External personnel are required to complete the following trainings at contracting and annually thereafter:

a. Compliance Program Manual – review of policies and procedures
b. Fraud, Waste, and Abuse Prevention Handbook – review of policies and procedures
c. Fraud, waste, and abuse – UHA Provider Training Orientation slide deck
d. False Claims Act, Oregon False Claims Act, and Whistleblower Protection - UHA Provider Training Orientation slide deck
e. HIPAA – Power point available on the Provider and Subcontractor Training page on UH's website
f. Compliance training (Code of Conduct and Ethics) – review of Code of Conduct and Ethics

Newly contracted external personnel shall receive training assignments at the following intervals:

a. Participating network providers, subcontractors and their workforce are provided with the Provider Orientation Training Slide Deck at onboarding.
b. The training slide deck is made available on the Provider and Subcontractor training page of the Umpqua Health website.
c. Participating providers
    i. Attestation of training completion for all newly contracted network providers and their workforce will be required within 30 days of assignment. UHM will monitor receipt of network provider and workforce staff attestations and ensure completion of attestation.
    ii. UHM will monitor and track attestations, following up every 14 days after due date has passed to ensure completion of assigned training.
    iii. Newly hired staff of network providers shall complete all identified trainings within 30 days of hire; an attestation of training completion shall be provided to UHM within 30 days of hire.

d. Newly contracted individual contractors, subcontractors, agents, first tier, downstream and related entities and their workforce shall complete training within 30 days of signed contract; an attestation of training completion shall be provided to UHA/UHM.
    i. Attestation of training completion for workforce staff of newly contracted individual contractors, subcontractors, agents, first tier, downstream and related entities and their workforce shall be required within 30 days of signed contract. UHA/UHM will monitor receipt of completed attestations.
    ii. UHA /UHM will monitor and track attestations, following up every 14 days after due date has passed to ensure completion of assigned training.
    iii. Newly hired staff of individual contractors, subcontractors, agents, first tier, downstream and related entities shall complete all identified trainings within 30 days of hire; an attestation of training completion shall be provided to UHA/UHM within 30 days of hire.
    iv. A workforce roster may be requested at the time of a Compliance performance review identifying training provided by staff delegated work under the CCO contract.
    i. Attestations of training completion for all workforce staff will be required within 30 days of assignment.
        1. UHM will monitor receipt of workforce training attestations and ensure attestations are completed for all workforce listed on roster.
        2. UHM will follow-up every 14 days after 30 days of training assignment has lapsed to ensure completion of assigned training.

Refresher annual trainings must be completed within 12 months of initial and subsequent years' training.

UHM will provide refresher trainings to all external personnel via email in the 3rd quarter of each calendar year. The training shall be emailed to the contact lead at each office.

1. External personnel assigned to UHA shall complete refresher training within 12 months of initial and subsequent years' training.
2. Attestations of training, including tracking logs and sign-in sheets, shall be completed and maintained by external personnel.
    i. During annual subcontractor compliance performance review, training attestations may be requested and reviewed.

ii. For participating providers, yearly UHM will select a random sample of provider offices and request attestations.

2. External personnel may elect to utilize their own trainings or request trainings from Umpqua Health.
    a. If utilizing its own training, external personnel must ensure that it aligns with the materials presented in:
        i. CMS Medicare Learning Network (http://www.cms.gov/MLNProducts).
        ii. Umpqua Health Alliance's Coordinated Care Organization contract with the Oregon Health Authority (Exhibit B, Part 9, Section 11).
        iii. Must align with CMS training and education resources found on https://www.cms.gov
3. External personnel may be required to provide evidence of completed trainings on an annual basis.
    a. Individuals and/or organizations that cannot provide evidence will be required to submit a corrective action plan to address the deficiency.
    b. Failure to address the lack of training may result in termination of the external personnel's contract.
4. Umpqua Health's Compliance Officer may grant an exception to this requirement for certain situations (e.g. Contractor is providing services on a limited basis, or services provided by the contractor do not necessarily support an administrative or health care service that Umpqua Health is required to provide).

Monitoring

1. New Hires
    a. The Human Resources Department and the Compliance Department will be monitoring completion of new hire onboarding compliance trainings through its LMS training platform.
        i. The LMS Training platform is configured to send automated notifications to staff and their direct supervisor when trainings are approaching the assigned due date.
        ii. This allows the Human Resources Department and the Compliance Department to monitor accurate timely completion of assigned trainings within the required assigned timeframe.
        iii. If staff are unable to complete their training within the assigned time frame, the LMS training platform's automated configured notification will notify the administrators, affected internal personnel, and their direct supervisor.

iv. Failure to complete trainings within required timelines will prompt notification to the employee's direct supervisor, Human Resources, and may result in disciplinary consequences as described above in item 6 under Internal Personnel: Employees, Providers, and Volunteers.
v. The Compliance Officer will be notified as necessary (i.e. continued failure to complete, trends in new hires not completing trainings, etc.).

2. Annual Training.
    a. The Human Resources Department and the Compliance Department will be monitoring completion of annual Compliance trainings through its LMS training platform.
    b. The LMS Training platform is configured to send automated notifications to staff and their direct supervisor when trainings are approaching the assigned due date. This allows the Compliance Department to monitor accurate timely completion of assigned trainings within the required assigned timeframe.
    c. If staff are unable to complete their training within the assigned time frame, the LMS training platform automated configured notification will notify the administrators, affected internal personnel, and their direct supervisor.
    d. The Compliance Officer will be notified as necessary (i.e. continued failure to complete, trends in new hires not completing trainings, etc.).
    e. Failure to complete trainings within required timelines will prompt notification to the employee's direct supervisor, Human Resources, and may result in disciplinary consequences as described above in item 6 under Internal Personnel: Employees, Providers, and Volunteers.

<u>Policies and Procedures</u>

UHA, who annually receives State payment under the agreement of at least $5,000,000, will maintain written policies for all employees of Umpqua Health, and any contractor or agent that provides detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers (see section: Internal Reporting and Fraud, Waste, and Abuse Prevention Handbook).

Monitoring and Auditing

Monitoring

Monitoring activities are a vital component of Umpqua Health's Compliance and FWA Prevention Program (see section: Monitoring and Fraud, Waste, and Abuse Prevention Handbook). It's important to note that monitoring is distinct from auditing as it provides room for a degree of subjectivity when assessing performance. Generally, departments report their own performance to fulfill contractual, State, and Federal obligations to the Compliance Department. Umpqua Health conducts monitoring internally with Key Performance Indicators (KPIs) and employs other internal monitoring methods such as routine reporting, committees, and workgroups.

Umpqua Health reserves the right to apply monitoring strategies to any of its external personnel to ensure they are routinely meeting contractual requirements (e.g. obtaining KPIs from a non-emergent transportation (NEMT) subcontractor to assess adherence to call center regulations).

Umpqua Health also monitors internal and external personnel against applicable State and Federal exclusion/debarment lists on a monthly basis, and promptly resolves matters in the event an individual or organization is actively sanctioned (see section: Screening of Individuals and Entities). Umpqua Health will not engage in or continue in a relationship with individuals identified as excluded/disbarred. Umpqua Health will report such individuals or entities to the Oregon Health Authority (OHA), the Oregon Department of Human Services (DHS) and the U.S. Department of Health and Human Services Office of Inspector General (OIG).

In an effort to monitor performance and manage risk, Umpqua Health uses a variety of monitoring strategies to evaluate its internal, external, and subcontractors' performance. The purpose of the policy is to outline the monitoring program for Umpqua Health, along with the reporting obligations.

RESPONSIBILITY

Compliance Department
Subcontractor Contact Leads
Health Plan Operations
Quality Improvement

PROCEDURES

Internal

1. Umpqua Health uses Key Performance Indicators (KPIs) to track progress on whether the organization meets certain required elements.

2. Annually, and as needed, KPIs will be established to measure performance against contractual requirements. This will entail:
    a. Identifying the regulatory requirement.
    b. Developing the methodology to track performance.
    c. Communicating to the department that will be required to report the KPI.
    d. Reporting frequently.
3. Departments assigned a KPI will be responsible to monitor performance and routinely supply that information to the Compliance Department.
4. At each reporting period, the Compliance Department will review the KPIs supplied by the other departments to determine whether the department is meeting contractual requirements.
5. Typically, a department performing below standards will be required to complete a risk response action (as identified by the Internal Risk Response Plan Process policy discussed below), if the following situations occur:
    a. Below but within 5% of threshold requirement for two or more consecutive reporting periods.
    b. Below and greater than 5% of threshold requirement for one or more consecutive reporting periods.
6. The Compliance Department may elect to develop other monitoring tactics outside of KPIs in response to investigation, inquiries, audits, etc. Examples include but are not limited to:
    a. Monthly Exclusion/Sanction monitoring.
    b. Post audit-finding mitigation activities.
7. All monitoring strategies will be communicated to the Board Oversight Compliance Committee for review.

<u>External</u>

1. To monitor external personnel, and/or subcontractors' performance Umpqua Health, in conjunction with the Compliance Department, Quality Improvement Committee, and Subcontractor Contact Leads may establish external monitoring tactics.
    a. These tactics will be in addition to Umpqua Health's Evaluation of Subcontractors program (see section: Evaluation of Subcontractor policy) and is not meant to replace subcontractor reviews.
2. Such strategies that may be considered include, but not limited to:
    a. Timeliness of claims processing.
    b. Claims accuracy.

c. Access and availability standards.

3. External personnel and/or subcontractors will communicate the required performance, risk response plan triggers, along with reporting timelines.
    a. In the event performance is below the required threshold, Umpqua Health reserves the right to ask the external personnel and/or subcontractor to complete a risk response action as outlined in section External Risk Response Process.
4. Umpqua Health's Compliance Department, or designee department, will receive and review reports using the established timelines.
5. Monitoring reports will be communicated to the Quality Improvement Committee and Umpqua Health's Board Oversight Compliance Committee.

Screening of Individuals and Entities

Umpqua Health and its subsidiaries are prohibited from establishing an employment or contracting relationship with any individuals or entities that are excluded or disbarred from Federal or State healthcare participation CCO Contract, Exhibit B, Part 9, Section 17(a); 42 Code of Federal Regulations (CFR) §§ 438.214(d) and 455.436; Oregon Administrative Rules (OAR) 410-141-3510(1)(e)).

The purpose of the policy is to identify the steps and responsibilities to screen internal and external personnel against exclusion databases.

RESPONSIBILITY

Compliance Department
Credentialing Department, and
Human Resources Department

PROCEDURES

No relationship shall be established or maintained with an individual or entity that has been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. Consequently, relationships will not be created or sustained with an individual or entity who is an affiliate, as defined in Federal Acquisition Regulation 48 CFR § 2.101, of a person or entity just described.

Internal Personnel

1. Prior to hire or contracting, the Human Resources Department will verify that potential internal personnel (with the exception of board members) are not excluded from federal or state healthcare participation. Databases that will be reviewed include**:**
    a. Health and Human Services Office of Inspector General's (HHS-OIG or OIG) List of Excluded Individuals (LEIE).
    b. Excluded Parties List System (EPLS), also known as System for Award Management (SAM).
    c. State licensing boards (for licensed individuals).
2. Umpqua Health's Compliance Department will conduct the initial review of the databases listed above for any new board members.
3. If potential internal personnel are identified on one of these databases, Umpqua Health will be prohibited from establishing an employment relationship with those individuals.
    a. Any individual found to be excluded from Federal or State healthcare participation will be reported to the Federal Department of Health and Human Services (DHHS) and OIG. This requirement may also be met by submitting the information to OHA Provider Services (CCO Contract, Exhibit B, Part 9, Section 17(a)).
4. Monthly, the Human Resources Department will supply a master file to the Compliance Department of all internal personnel currently employed by Umpqua Health.
5. The Compliance Department will monitor all internal personnel on a monthly basis against the following databases:
    a. LEIE.
    b. EPLS.
6. The Human Resources Department will monitor all licensed internal personnel on a monthly basis against the following database:
    a. State licensing boards (for licensed individuals).
7. If at any point during the monthly monitoring process an individual is identified on any one of the databases, the Human Resources and Compliance Department will coordinate and determine mitigation strategies, up to and including termination.
    a. In the event internal personnel are identified as sanctioned, Oregon Department of Human Services (DHS), DHHS, OIG, and OHA's Provider Enrollment Unit (via Administrative Notice) will be promptly notified, and the relationship with Umpqua Health will cease. This requirement may also be met by submitting the

information to OHA Provider Services (CCO Contract, Exhibit B, Part 9, Section 17(a)).

8. In the event a network provider's circumstances change in such a way as to potentially affect the eligibility of that provider to participate in the managed care program, including the termination of the provider agreement with Umpqua Health, OHA will be notified.

External Personnel

1. Prior to engaging in a contractual relationship with an individual or entity, Umpqua Health will ensure the following databases are reviewed:
    a. LEIE.
    b. EPLS.
    c. State licensing boards (for licensed individuals).
2. The Human Resources Department, using, but not limited to, a tax identification number or social security number, will conduct the screening for external personnel (except for network providers).
    a. The Credentialing Department will conduct the screening for the network providers.
3. If potential external personnel are identified on one of these databases, Umpqua Health is prohibited from establishing an employment relationship with those individuals.
    a. Any individual found to be excluded from Federal or State healthcare participation will be reported to DHHS and OIG. This requirement may also be met by submitting the information to OHA Provider Services (CCO Contract, Exhibit B, Part 9, Section 17(a)).
4. Monthly, the Human Resources and Credentialing Department will supply a master file to the Compliance Department of all external personnel contracted with Umpqua Health.
    a. For those external personnel not credentialed by the Credentialing Department the Compliance Department, at any time, may request an exclusion report from the delegated external personnel including all employees of external personnel.
5. The Compliance Department will monitor all external personnel on a monthly basis against the following databases:
    a. LEIE.
    b. EPLS.
6. If at any point during the monthly monitoring process an individual is identified on any one of the databases, the Human Resources, Compliance, and/or Credentialing

Departments will coordinate and determine mitigation strategies, up to and including termination of the contractual relationship.

   a. Additionally, should external personnel be identified as sanctioned, DHHS and OIG will be promptly notified and the relationship with Umpqua Health will cease. This requirement may also be met by submitting the information to OHA's Provider Services via Administrative Notice (CCO Contract, Exhibit B, Part 9, Section 17(a)).

7. The Compliance Department will include as part of the Annual Subcontractor Performance Report whether employees of the subcontractor are screened and monitored for Federal exclusion from participation in Medicaid (CCO Contract, Exhibit B, Part 4, Section 11(a)(14)(d)).
   a. If during the subcontractor audit review process an individual is identified on the subcontractor's exclusion report deliverable, the Compliance and Credentialing Departments will coordinate and determine mitigation strategies, up to and including termination of the contractual relationship.
      i. Additionally, should external personnel be identified as sanctioned, DHHS and OIG will be promptly notified and the relationship with Umpqua Health will cease. This requirement may also be met by submitting the information to OHA's Provider Services via Administrative Notice (CCO Contract, Exhibit B, Part 9, Section 17(a)).
8. In the event a network provider's circumstances change in such a way as to potentially affect the eligibility of that provider to participate in the managed care program, including the termination of the provider agreement with Umpqua Health, OHA will be notified.

Auditing

Umpqua Health's Audit Program allows the organization to assess performance objectively against contractual, state, and federal requirements, thus serving as an additional risk assessment tool. Umpqua Health's Audit Program is divided into Provider, Subcontractor, Internal, External, and Program Integrity Audits.

Provider Audit: Audits conducted by Umpqua Health Alliance (UHA) involve the evaluation of panel providers to assess their adherence to contractual obligations, policies, and other relevant criteria. Provider Audits are also structured to identify instances of FWA. For instance, one aspect of these audits involves evaluating a provider's member access and availability to ensure they meet established standards.

Subcontractor Audit: UHA has a mandatory annual monitoring requirement for subcontractors. These audits serve the purpose of confirming that subcontractors are in compliance with the contractual obligations delegated to them (as outlined in sections Subcontractor – General Requirements and Subcontractor – Written Requirements). Examples of a subcontractor audit include, but are not limited to:

- Reviewing a third-party administrator's claims processing system.
- Assessing a NEMT subcontractor for compliance with OARs 410-141-3915 through 410-141-3965 as well as validating claims/encounters for services rendered (CO29 – NEMT Quality Assurance Program and Plan).

Internal Audit: Internal audits can occur through any one of Umpqua Health's entities and typically will be conducted by the Compliance Department (as outlined in section Internal Auditing). These reviews will examine various other Umpqua Health entities and departments to ensure their compliance with contractual, State, and Federal requirements. Types of Internal Audits may encompass, but are not limited to:

- Evaluation of internal processes, such as the grievance process
- Evaluation of materials provided to members.
- Examination of claims against network provider charts to verify the accuracy of encounter claims.

External Audit: Planned or unplanned audits by a regulatory entity.

Fraud, Waste, and Abuse Audit: These audits are examinations and assessment conducted by UHA to identify and mitigate instances of any potential fraud, waste, and abuse. Each audit focuses on elements to determine the level of intention.

- Audit focus for fraud: this audit will investigate activities that may indicate potential fraudulent behavior, such as embezzlement, bribery, corruption, or falsification of records. This audit would have to prove intentional deception or misrepresentation to achieve a financial or personal gain at the expense of UHA.
- Audit focus for waste: This audit will examine processes, operations, and expenditures to identify instances where resources are being used inappropriately or where there is an opportunity to optimize resource allocation.
- Audit focus for abuse: this audit will assess whether there are instances of abuse, such as misuse of authority, violation of UHA policies and procedures, the CCO Contract, provider/subcontractor contracts, or improper use of assets, that could negatively impact UHA.

Program Integrity (PI) Audit: Audits conducted by UHA to target activities associated with FWA. PI Audits are done in both a proactive and retrospective manner to identify potential situations of FWA. Types of PI Audits may include, but are not limited to:

- Evaluation of providers for excessive utilization of services.
- Examination of Medicaid claims for irregular billing practices, to determine if FWA has or is likely to occur, or whether actions of individuals or entities have the potential for resulting in an expenditure of Medicaid funds which is not intended under the provisions of the CCO Contract, State or Federal Medicaid regulations. This assessment also aims to identify instances of improper payments.
- Evaluation of Drug Related Group (DRG) claims to determine their compliance with current pricing guidelines.
- Review of Evaluation and Management (E/M) claims to ensure they align with current E/M coding guidelines and review of high E/M code utilizers.
- Referrals from the Oregon Health Authority Office of Program Integrity and the Medicaid Fraud Control Unit.

Fraud, Waste, and Abuse; PI Audits; and Provider Audits

Umpqua Health routinely engages in FWA audits, PI audits, and provider audits, please see UHA's Fraud, Waste, and Abuse Prevention Handbook for further information.

Subcontractor Auditing

Umpqua Health routinely engages in subcontractor audits, please see section Subcontractors of this Compliance Program Manual for further information.

Internal Auditing

Umpqua Health routinely engages in Internal Audits to verify the organization is meeting contractual, State, and Federal requirements.

This policy outlines the Internal Audit steps, reporting obligations, and the requirements for all internal personnel to cooperate and respond appropriately to Internal Audits.

RESPONSIBILITY

Compliance Department

PROCEDURES

1. Umpqua Health routinely conducts Internal Audits to ensure the organization is meeting certain requirements.
2. Internal Audits are typically planned through the Annual Compliance and FWA Work Plan's Internal Audit Appendix 2. Umpqua Health's Compliance and FWA Work Plan

   a. However, the organization may elect to conduct ad hoc Internal Audits, often in response to an inquiry, investigation, or reported issues.
3. The Compliance Department will make reasonable efforts to accommodate the department(s) being audited to minimize disruption to workflows and day-to-day operations. Such accommodation may include but not be limited to:
   a. Extending timelines for a deliverable.
   b. Reducing the number of meetings and follow up activities.
   c. Modifying the scope of an audit, if appropriate.
   d. Delaying an audit, if necessary.
4. However, all internal personnel are required to fully cooperate with any Internal Audits. Deliberate refusal to cooperate in an Internal Audit, may result in disciplinary actions, up to and including terminations. Such activities that may be problematic include, but are not limited to:
   a. Failure to supply requested deliverables within the required timeframes.
   b. Refusal to turn over deliverables, data, policies, etc.
   c. Refusal to answer questions, make staff available, or provide necessary resources.
   d. Refusal to accept Internal Audit results without valid reasons.
   e. Delay or refusal to make corrective actions to deficiencies identified.
5. In the event a department displays some of the conduct identified above, the Compliance Officer will engage the Human Resources Department and the Chief Executive Officer for possible sanctions and remediation.
6. Once it has been determined that an Internal Audit is needed, the Compliance Department will gather and develop the necessary tools, including identifying the requirements that will be evaluated.
7. The Compliance Department will schedule an Entrance Conference to provide a "Notice of Internal Audit," to the Department(s) Executive Team Member(s).
   a. Executive Team Member(s) may elect to have additional personnel attend and participate in the Internal Audit.
8. The "Notice of Internal Audit," will provide the Department(s) being audited the following:
   a. Scope of audit;
   b. Line of business being audited;
   c. Entrance Conference date; and
   d. Requested deliverable and timeframes.
      i. Deliverables should be supplied to the Compliance Department typically two (2) weeks after the "Notice of Internal Audit" provided at the Entrance Conference.
9. The Compliance Department may use a variety of activities to conduct the audit, and the department(s) are requested to comply and cooperate with any of the activities. Such activities may include:
   a. Data review.
   b. Desk audits.

c. Policy review.
d. Staff interviews.
e. Job shadowing.

10. During the course of the audit(s), the Compliance Department may ask for additional deliverable(s), and department(s) are expected to comply and assist with any requests.
11. Once the audit is complete, a drafted Internal Audit – Preliminary Findings Notice will be reviewed by Compliance Department leadership before it is distributed. The notice must include:
    a. Elements evaluated.
    b. Any findings; and
    c. Date of the exit conference.
12. Upon leaderships' approval the Compliance Department will provide a "Notice of Preliminary Findings," to the department(s) audited. The Notice will identify the elements evaluated, and whether any findings were identified. The Compliance Department will also schedule an Exit Conference (typically one to two weeks after the Notice).
13. At the Exit Conference, the Compliance Department will review with the department(s) the "Notice of Preliminary Findings," and receive any feedback if there are concerns related to any of the findings. Additionally, the department(s) will be requested to supply a risk response plan for any unresolved findings at the Exit Conference.
    a. If the department(s) have a dispute with any findings, the Department(s) and the Compliance Department will determine a fair and appropriate way to determine its merit.
    b. If the disputed finding is confirmed, the Compliance Department will ensure the final "Notice of Completed Internal Audit," that the specific audit element was disputed but was later confirmed as an accurate finding.
    c. If the disputed finding is overturned, the Compliance Department will issue the final "Notice of Completed Internal Audit." The Notice will document the correct assessment with a notation that the element was initially identified as a finding but was overturned after dispute.
14. The final Internal Audit Report will be submitted to the Compliance Officer for review.
15. After completion of the Exit Conference, if there are no disputed/unresolved findings and risk response plans have been identified, the Compliance Department will complete a final "Notice of Completed Internal Audit." Recipients of this Notice will be:
    a. Department(s) audited, including the Executive Team Member(s) for the department(s), along with participants;
    b. Compliance Officer; and
    c. Chief Executive Officer.
16. Department(s) with findings will be moved into the risk response plan process as identified by policy the Internal Risk Response Plan Process section of this manual.
17. The Compliance Department will report all Internal Audits to the Executive Team (if needed), as well as Umpqua Health's Board Oversight Compliance Committee.

a. Depending on the nature of a certain finding, Internal Audits may also be reported to Umpqua Health's Board of Directors.

Reporting Mechanism

Hotline & Compliance Department Support

The Umpqua Health hotline is available to all individuals, both inside and outside the organization, including members, patients, concerned individuals, subcontractors, and providers within the community. The hotline is a vital component of the Compliance and FWA Prevention Program, enabling individuals to anonymously report compliance and FWA concerns anonymously through a third party. It also offers a system for receipt, recording, and response to compliance questions. The hotline, coupled with a proactive and supportive Compliance Department, establishes an efficient channel of communication. It also promotes an open-door policy within the organization, facilitating the reporting of compliance issues among the Compliance Officer, members, employees, providers, and subcontractors.

Umpqua Health's Compliance and FWA Prevention Program actively encourages all its internal and external personnel to report any potential problematic activities, including situations of fraud, waste and abuse, as well as any arrests or convictions. It is the responsibility of both internal and external personnel to promptly report compliance and FWA issues. Umpqua Health is committed to creating a safe environment for individuals who report or act as whistleblowers and strongly prohibits any form of retaliation against personnel who report matters in good faith (CO9 – Non-Retaliation).

The Compliance Department, the Board of Directors, and Umpqua Health Leadership are responsible for actively promoting its hotline and compliance resources through education and awareness. Umpqua Health's Compliance hotline can be accessed via the following options:

Compliance & FWA Hotline (Anonymous reporting available)
Phone: (844) 348-4702
Online: www.umpquahealth.ethicspoint.com

The Compliance Department always has an open door and welcomes questions, concerns, and inquiries from individuals inside and outside the organization. The Compliance Department can be reached via the following options:

Compliance Department
Phone: (541) 229-7081
Email: compliance@umpquahealth.com

Additionally, such concerns may also be reported through UHA's Member Grievance and Appeals Program, which also allows for anonymous reporting. When utilizing this method, callers are still safeguarded by the organization's zero-tolerance policy against any form of retaliation.

The Compliance Department prides itself on maintaining confidentiality. Confidentiality is a cornerstone of the Compliance Department's commitment to fostering a culture of trust and transparency within our organization. The Compliance Department recognizes the importance of, and the sensitivity of the information individuals may bring forward when posing questions or making a report. The Compliance Department is dedicated to safeguarding identities and concerns.

The purpose of this policy is to outline the requirement for Umpqua Health to maintain a hotline for individuals to ask compliance questions and report compliance matters, along with the responding and reporting process for hotline reports.

PROCEDURES

1. In accordance with Exhibit B, Part 9, Sections 11(b)(14) and 12(a)(1)(c)&(d) of Umpqua Health Alliance's Coordinated Care Organization (CCO) Contract with the Oregon Health Authority (OHA) and 42 CFR § 438.608, Umpqua Health has contracted with a third-party vendor to establish a hotline for individuals to report compliance matters.
2. The Compliance Department is tasked with promoting the hotline through various means to the following individuals:
    a. Internal personnel.
    b. External personnel
    c. Members.
    d. Patients.
    e. Patient/Member Representative.
    f. Providers
3. Promoting the hotline will include communications outlining the anonymous reporting benefit that the hotline provides.
4. UHA uses a Case Manager Database to receive questions and allegations related to Compliance issues from employees, providers, subcontractors, and members. The system, which allows individuals to remain confidential, allows the Compliance staff to track, triage and/or respond to questions and allegations. Potential next steps may include:
    a. Research and respond to compliance questions, which includes the option to respond to confidential questions.

b. To ensure confidentiality of those posing a question or submitting an allegation, only the Chief Compliance Officer, Compliance Officer and select Compliance staff have access to the Case Manager Database.
c. Compliance Department investigation and resolution, which may include further compliance, correction action, or opening a Program Integrity Audit to recover overpayments.
d. Referral to the Medicaid Fraud Control Unit (MFCU)/ OHA Office of Program Integrity (OPI) for fraud or abuse
e. or (ii) to its Compliance Department to investigate, resolve, and refer the final case internally for further compliance, corrective action, or to open a Program Integrity audit to recover overpayments.
f. UHA is prohibited from referring allegations to a subcontractor who is also a party to the allegation.

5. Additionally, the Compliance Department will periodically review the effectiveness and availability of the hotline and take necessary actions in the event the hotline becomes unavailable or ineffective.
6. Hotline reports will be reviewed by the Compliance Department and documented in the Compliance Log.
    a. The Compliance Department will determine whether an investigation is warranted, and if necessary, begin the investigation process.
        i. If contact information is provided by the reporter, the Compliance Department will reach out to the reporter for more information if necessary.
    b. In the event, the report is a non-compliance matter (e.g. Human Resources matter), the Compliance Department will document the report in the Compliance Log and note that the information was forwarded to the appropriate department for follow up.
7. The Compliance Department will provide a summary of the volume of hotline calls to the Board Oversight Compliance Committee on a quarterly basis. This Committee will evaluate and ensure that the Compliance Department is appropriately promoting the hotline and ensuring its availability.
8. The hotline can be accessed through the following means (Can report anonymously):
    a. Phone: (844) 348-4702
    b. Online: www.umpquahealth.ethicspoint.com
9. To further support and encourage reporting, UHA and its parent company, Umpqua Health, has a strict zero-tolerance policy on retaliation (CO9 – Non-Retaliation) to ensure

internal personnel, external personnel, and its members are protected from retaliation under applicable whistleblower laws.

Regulatory Reporting

Contractually, UHA has an obligation to report any suspicious activities related to fraud, waste and abuse to Oregon's Medicaid Fraud Control Unit ("MFCU"), OHA Office of Program Integrity (OPI), and/or DHS Fraud Investigation Unit. This collaboration ensures State agencies are collectively aware of FWA activities conducted by UHA. In addition, UHA is required to report other elements (i.e. provider sanctions, suspicions of fraudulent activity, overpayments, changes in provider or member circumstances) to regulatory bodies, which is further discussed in the Fraud, Waste, and Abuse Prevention Handbook .

Finally, if UHA is notified by MFCU of a credible allegation of fraud or of a pending investigation against a provider, UHA is required to suspend payments to the provider. However, there may be instances where MFCU determines there is good cause not to suspend payments or to suspend payments only partially, in accordance with the criteria set forth in 42 CFR §455.23. This specific procedure is detailed further in the Fraud, Waste, and Abuse Prevention Handbook.

Internal Reporting

Umpqua Health's Compliance Program is predicated on internal personnel reporting compliance matters in a timely fashion. Additionally, it is the responsibility of all internal personnel to report compliance matters, regardless of whether the conduct has been confirmed.

The purpose of the policy is to establish the requirement that all internal personnel are required to report compliance issues to the Compliance Department without any intent to hide, conceal, or prevent an issue from being reported.

RESPONSIBILITY

All

PROCEDURES

1. In order to have an effective Compliance Program and to ensure issues are investigated and mitigated appropriately, all internal personnel are required to report suspicious compliance matters.
    a. Matters are to be reported when they are received, and internal personnel shall not attempt to substantiate an allegation prior to making a report.

2. All internal personnel are required to report any arrest and conviction within one (1) business day of occurrence, including any suspected criminal activities informed of, witnessed, observed, or identified via audit.
3. Internal personnel can satisfy these requirements by reporting to the following:
    a. Supervisors and/or Management.
        i. Supervisors and Management are then required to report this information immediately, but no later than one (1) business day to the Compliance Department.
        ii. Supervisors and Management should not take steps to substantiate an allegation without first consulting the Compliance Department.
    b. Human Resources Department.
        i. The Human Resources Department will forward the report to the Compliance Department, within one (1) business day.
    c. Compliance Department.
    d. Compliance Hotline (can report anonymously).
4. In the event it is determined that an internal personnel was aware of an issue, but did not report that matter, the internal personnel will be subject to discipline, up to and including termination.
5. Umpqua Health has a strict non-retaliation policy (see CO9- Non-Retaliation); therefore, internal personnel are protected for reporting matters in good faith. In the event internal personnel are fearful to report a compliance matter due to retaliation they can engage in the following steps:
    a. Speak to the Human Resources Department.
    b. Speak to the Compliance Department.
    c. Contact the Compliance Hotline (can report anonymously).

External Reporting

Umpqua Health is dedicated in cooperating with external stakeholders and law enforcement agencies; therefore, in the event a compliance issue is identified that requires reporting to external stakeholders and/or law enforcement agencies, Umpqua Health will promptly and appropriately report such matters.

The purpose of the policy is to establish the reporting obligations and process to report compliance matters to external stakeholders.

RESPONSIBILITY

Compliance Department
Human Resources Department

PROCEDURES

General

1. At times, a Compliance or Human Resources matter may result in further disclosure to external stakeholders as required by contractual, State, and Federal regulations. Some examples include, but are not limited to:
    1. An employee licensure problem.
    2. A network provider credentialing issue, including if a provider has been identified on the List of Excluded Individuals or on the Excluded Parties List System (aka system for Aware Management (SAM)).
    3. Contract deficiencies associated with Umpqua Health Alliance's Coordinated Care Organization Contract with the Oregon Health Authority (OHA).
    4. Contract deficiencies associated with services delegated by Atrio to Umpqua Health.
    5. Claims overpayments.
    6. Stark, Anti-Kickback, or False Claims Act matters.
2. In the event a potential issue is identified, the Compliance Department will coordinate with applicable departments, Legal Counsel, or law enforcement agencies.
3. If necessary, the Compliance Department will coordinate with other departments to gather additional information. If necessary, a larger investigation will be conducted in order to properly report the mater externally.
4. The Compliance Officer will supply information to the Board Oversight Compliance Committee and Umpqua Health's Board of Directors in the event of any substantial external reporting situations.

External FWA Reporting Requirements (see Fraud, Waste, and Abuse Prevention Handbook for details)

1. Reporting of Sanctioned and Excluded Individuals or Entities
    a. UHA must immediately report to the OIG any providers identified during the credentialing process, who are included on the Health and Human Services of Inspector General's (HHS-OIG) 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.

b. Furthermore, any such persons or entities identified through Umpqua Health's monthly monitoring of the LEIE, EPLS and other such databases, will also be reported to HHS-OIG.

2. For referrals to Medicaid Fraud Control Unit (MFCU) and/or OHA Office of Program Integrity (OPI) and DHS Fraud Investigation Unit see the Fraud, Waste, and Abuse Prevention Handbook.
3. Overpayments.
    a. In the event an overpayment pertaining to capitation payments or other payments is identified through a Program Integrity (PI) audit as being fraudulent, a report will be made to OHA within 60 calendar days (42 CFR § 438.608(d)) (see Fraud, Waste, and Abuse Prevention Handbook for details).
        i.
    b. In the event of financial recoveries from audits conducted by UHA or subcontractors of network providers or encounter claims data, UHA is permitted to keep the recovered amount outside of any applicable federally matched funds which must be returned to OHA.

<u>Correction or Coordination of Suspected Criminal Acts with Law Enforcement Agencies</u>

1. All internal personnel of Umpqua Health Management (UHM) are trained on Umpqua Health's internal reporting policy that details any criminal acts (suspected or factual) are to be reported to the Compliance Department within one (1) business day.
2. In the event Umpqua Health receives a report, identifies, or suspects criminal activities and/or fraud, waste, and abuse through data analytics and regular audits, the Compliance Officer will conduct a preliminary assessment within 24 hours to determine the credibility and seriousness of the reported criminal act and evaluate the potential risk, including legal and financial implications for Umpqua Health. The Compliance Officer will prepare a summarized preliminary report of the findings, including evidence of criminal activity and consult with the Chief Compliance Officer to determine if a legal review should be initiated.
3. An investigation will be conducted by Compliance Department personnel, which may involve legal counsel, based on the nature and complexity of the suspected criminal act.
    a. The investigator will work with the Compliance Officer to define the scope, objectives, and methodologies for the investigation. The investigator will aim to complete the investigation within 30 days of the assignment.
    b. The investigator will:
        i. Collect relevant data, such as financial records, communication logs and witness statements.

ii. Conduct interview with involved parties while maintaining confidentiality and the non-relation policy.
iii. Work with the Compliance Officer and legal counsel if necessary to analyze the collected data to identify evidence of criminal activity.
    1. If a legal review is necessary, the Compliance Officer will engage legal counsel to determine if the incident involves criminal acts that require reporting to law enforcement.

4. Correction and Immediate Actions.
    a. The investigator will work with the Compliance Officer to prepare a detailed report of the findings, including all relevant evidence and a summary of the investigation.
    b. The Compliance Officer will take immediate action to stop ongoing criminal activities (e.g., ensuring payment suspension).
    c. In the event the suspected or factual criminal act is determined to be committed by UHM internal personnel, the Compliance Officer will engage the Human Resources Department (CO19 - Disciplinary Process for Compliance Infractions).
    d. A corrective action plan will be developed and implemented to address and remediate findings, identified weaknesses, and prevent recurrence of similar incidents. Such corrective action may include updating policies and procedures to strengthen controls and mitigate risks of future criminal activities; targeted training and awareness sessions for internal personnel on recognizing and reporting criminal activities, and/or implementing awareness programs to reinforce the importance of compliance and ethical behavior.
5. Reports of suspected criminal acts will be made to appropriate law enforcement agencies (e.g. local police, FBI, or specialized agencies like Office of Inspector General (OIG), MFCU, or OHA OPI) will be made within 7 business days following the conclusion of the investigation and consulting with legal counsel. The Compliance Officer will provide all necessary documentation and will coordinate and cooperate with law enforcement agencies throughout their investigation, ensuring compliance with legal requirements and Umpqua Health's policies and procedures.
    a. An overview of the suspected or factual criminal activity will be provided with the notification. Supporting documentation, including the investigation report, evidence, and any relevant communications will be submitted with the notification.
    b. The Chief Compliance Officer or Compliance Officer will be designated as point of contact for Umpqua Health for any notification that is submitted for suspected or factual criminal activity to act as the liaison with law enforcement agencies.
6. Umpqua Health will fully cooperate with law enforcement agencies, providing additional information or documentation as requested and if available.
    a. If law enforcement request access to relevant personnel and resources within Umpqua Health the request must be directed to the Chief Compliance Officer or Compliance Officer.

b. If law enforcement should request meetings or request to engage in discussion, Umpqua Health will respond promptly to any such request.

Reporting of Assessment of Compliance and FWA Documents and Activities

1. For Quarterly and Annual FWA Audit Reports see Fraud, Waste, and Abuse Prevention Handbook.
2. UHA shall review and update its Compliance Program Manual and Fraud, Waste, and Abuse Prevention Handbook annually. These documents shall be provided to OHA Contract Administration Unit via Administrative Notice through OHA's deliverable portal:
   a. For annual review submission occurs no later than January 31st unless the Organization attests to no changes since the last submission using OHA's "Fraud, Waste, and Abuse Annual Attestation Template";
      i. OHA approval must have been received in contract year immediately preceding the contract year in which the UHA would like to submit its attestation.
      ii. In no event will UHA submit an attestation of no changes to its Compliance Program Manual and Fraud, Waste, and Abuse Prevention Handbook in two (2) consecutive contract years.
      iii. When significant material revisions are made or prior to initial adoption of a new plan or handbook; or
      iv. Whenever OHA requests these documents for review.
   b. In response to such submissions, OHA will notify UHA via Administrative Notice to UHA's Contract Administrator within 60 days of the compliance status of the policy.
   c. For Annual FWA Assessment Report see Fraud, Waste, and Abuse Prevention Handbook.

3. In the event OHA identifies deficiencies within the required compliance and FWA submitted documentation, actions will be taken to remedy the findings in accordance with the process set forth in Exhibit D, Section 5 of the CCO Contract to remedy the findings as expeditiously as possible.

Subcontractor Reporting

1. See section: Evaluation of Subcontractor for details

Enforcement & Discipline

Umpqua Health is committed to a robust Compliance & Ethics Program and FWA Prevention. A key component of such program is ensuring compliance infractions are met with appropriate corrective action, and if necessary disciplinary actions, which are equitable for all internal personnel throughout the organization.

When compliance concerns involving both internal and external personnel are identified, the Compliance Department collaborates with the Human Resources Department and other relevant departments, such as the Provider Network Department. This collaborative effort ensures that fair and consistent disciplinary actions are taken and that necessary mitigation measures are implemented for both internal and external personnel. Umpqua Health's policies establish clear disciplinary standards for both its internal and external personnel. These standards are widely disseminated and made accessible through various means, including the Employee Handbook, external contracts and agreements, company policies, and other relevant channels. Furthermore, individuals who breach Umpqua Health's Code of Conduct can anticipate facing disciplinary actions. Umpqua Health is committed to upholding a disciplinary process that is consistently fair and equitable to all internal and external personnel (CO19 – Disciplinary Process for Compliance Infractions).

Response & Prevention

Response – Investigation Process

Umpqua Health is committed in ensuring that internal and external personnel understand the importance of an investigation, and therefore insists internal and external personnel cooperate fully with any investigation conducted or participated by Umpqua Health.

The investigation process is an essential element of every Compliance and FWA Prevention Program. Investigations, including those of potential FWA, can be triggered from a variety of activities such as hotline reports, investigations, audits, program integrity audits, data mining, process review and through the course of self-evaluation. This organization's Compliance and FWA Prevention Program has systems in place to effectively evaluate and review Compliance and FWA matters (See Fraud, Waste, and Abuse Prevention Handbook for FWA policies and procedures).

Additionally, HIPAA requires certain steps to be conducted when evaluating whether a privacy or security incident results in a breach of patient/member information, which Umpqua Health must follow as a covered entity and business associate. Umpqua Health expects all of its internal and external personnel to cooperate with any investigation that might occur (See section: Cooperating with Subpoenas and Investigations).

Cooperating with Subpoenas and Investigations

The purpose of the policy is to establish the requirement that all personnel are required to comply with any investigation conducted or participated by Umpqua Health.

RESPONSIBILITY

All

PROCEDURES

1. During the course of one's employment or contractual relationship with Umpqua Health, an individual or entity may be asked to participate in an investigation(s) conducted or participated by Umpqua Health.
2. It is the expectation that all internal and external personnel fully cooperate with any Umpqua Health's investigations.
3. Internal or external personnel who refuse to cooperate, deliberately jeopardize an investigation, are not truthful, or engage in any other contact that harms an investigation may be subject to disciplinary actions, up to and including termination of employment or contractual relationship.

a. In the event personnel does not cooperate or causes disruption with an investigation the Compliance Officer will coordinate with the Human Resources Department and the Chief Executive Officer for potential sanctions.

4. Receipt of a subpoena:
    a. Umpqua Health's Compliance Department is designated as the point of contact for all subpoena's received for any line of business.
        i. Immediate notification of all subpoenas must be submitted to compliance@umpquahealth.com.
    b. The Compliance Department will review the subpoena to ensure its validity, legality, and relevance to the organization.
        i. The Compliance Department will engage executive team members, any department or internal personnel impacted by the subpoena, or legal as appropriate.
    c. Documentation.
        i. All subpoenas will be logged in the subpoena tracking log maintained by the Compliance Department.
    d. Communication Protocol.
        i. The Compliance Department will inform affected department(s) or internal personnel if they have been cleared to participate in the subpoena or whether additional documentation must be received to comply.
        ii. Any external communication must be guided by the Compliance Officer to ensure inquiries related to the subpoena are coordinated and consistent.
        iii. If at any point public communication is warranted, policy M3 – Media Relations will be followed.

Internal Investigations Process

The purpose of this policy is to establish the structure and the Compliance Department approach to investigating potential violations of internal policies and procedures, State and Federal laws, regulations, contractual obligations, or implemented standards Umpqua Health is regulated by.

RESPONSIBILITY

Compliance Department

PROCEDURES

1. The Compliance Department may receive reports via email, by phone, or through its establish hotline. Referrals may come from internal or external personnel.
2. Once a concern has been expressed via phone, email, or hotline, the Compliance Officer will assign the case to an appropriate Compliance Department team member as the investigator.
3. The investigator will determine the scope of the investigation and determine what resources are needed. The hotline case management system will be used to triage, track, document detailed records of all findings, interviews, risk assessments, evidence, and outcomes, all supporting documentation is to be uploaded to the attachment section of the case file in the hotline case management platform.
4. Once the preliminary review determines potential substantiation of the allegation/report and it involves internal staff, the investigator will send out a Compliance Investigation Notice to the Compliance Officer (if not assigned to the case), the Director/or Manager of the employee, and the Human Resources Department designee.
5. The investigator will begin information gathering to collect relevant information (e.g., documents, emails, policies, interviews, root-cause analysis, video surveillance, phone recordings, onsite assessments, job shadowing, etc.)
    a. If an interview is necessary, the Compliance Department will schedule time with the applicable employee and/or management to corroborate information obtained. Any additional identified individual(s), the Compliance Department may schedule interviews with them to gather testimonial(s) or additional insight.
6. Once the information has been collected, the information is reviewed and analyzed to gather an understanding of the nature and intent to make a determination of the extent of the allegation/report of non-compliance.
    a. If non-compliance is substantiated, the investigator and the Compliance Officer will discuss recommended actions to be taken to address the issue. These recommendations may include implementing corrective measure, disciplinary

actions, policy revisions, additional training, or any other necessary step to prevent reoccurrence.

7. Upon conclusion the investigator evaluates the evidence collected and assesses whether non-compliance occurred. The investigator will summarize their findings from the investigation in a Closure of Compliance Investigation notice. The notice will also describe conclusions and any recommendations being made by the Compliance Department. The Closure Notice will be sent to the same individuals informed on the Compliance Investigation Notice.
    a. Upon notice of closure and receipt of the Compliance Department's recommendations, the Human Resources Department and the Director/Manager will review recommendations and make the final determination on any actions taken. They must then provide a response back to the Compliance Department within the timeframe outlined in the Closure Notice to document within the case file before formally closing the case.
        i. If the Human Resources Department and/or management disagrees with the recommendations, the process outlined in CO19- Disciplinary Process for Compliance Infractions must be followed.
8. Any follow-up or monitoring that must occur with an employee following the case closure will be conducted by the Human Resources Department and Director/Manager.
9. Any follow-up or monitoring of policy correction or implementing corrective action related to internal processes will be conducted by the Compliance Department.
10. Throughout the entire investigation process the Compliance Department understands the importance of maintaining confidentiality, objectivity, and fairness.

Prevention – Risk Response Plan

In the event it becomes known that Umpqua Health's internal or external personnel engage in conduct that is incongruent with regulatory or contractual requirements, Umpqua Health will assign a Risk Response Plan (RRP) to address such deficiencies.

Umpqua Health's Compliance Department developed a process to apply and track actions to assure the issues are successfully mitigated. Each situation is unique, therefore the RRP may vary but may include, but not limited to:

- Revision of policies or procedures
- Training
- Recovery of overpayment
- Notification of identified issues
- Improvement plans
- Disciplinary actions
- Reassignment of duties
- Termination of contract

The RRP process is crucial in the Compliance and FWA Prevention Program (see sections: Internal Risk Response Process and External Risk Response Process).

Umpqua Health's RRP is designed to promote a culture of continuous improvement with an understanding that mistakes do happen. The critical aspect of the RRP process is to quickly and effectively understand the risk and apply necessary actions to resolve the situation. The process is collaborative in order to rectify the matter. Naturally, there may come a time during the RRP process in which escalation is needed, and in such situations the Compliance Department will work with leadership, the Board of Directors, and other stakeholders to escalate the matter accordingly (e.g. termination of employment, contract termination, etc.). In addition, the Compliance Department has a strong reporting process through the Board Oversight Compliance Committee to ensure RRPs are resolved appropriately and in a timely manner.

To ensure compliance across critical areas such as claims processing, prior authorization, service verification, utilization management, and quality review, Umpqua Health has established a comprehensive risk evaluation and assessment framework. This framework is designed to identify, evaluate, and mitigate risks, thereby ensuring adherence to regulatory requirements and organizational standards. Standard Operating Procedure SOP-C01-3 outlines the process for identification, evaluation, and mitigation of mitigate potential compliance risks and FWA activities within the organization.

Internal Risk Response Process

This policy serves to outline the risk response process for internal personnel and ensure proper follow through in order to properly mitigate known issues.

RESPONSIBILITY

Compliance Department

PROCEDURES

General

1. In accordance with Exhibit B, Parts 2, 4, 8, and 9 of Umpqua Health Alliance's Coordinated Care Organization (CCO) contract with the Oregon Health Authority (OHA) and 42 CFR § 438.608, Umpqua Health will engage in a risk response process to address any deficiencies that become known to the organization.
2. Umpqua Health's risk response process is a multilayered approach to ensure deficiencies are swiftly rectified. Mitigation of identified deficiencies may be dealt with in using the following means:
    a. Notification of Opportunity (Notice).
    b. Opportunity Plan (OP).
        i. 180 days to complete.
    c. Corrective Action Plan (CAP).
        i. 90-days to complete.
        ii. 60-days to complete.
        iii. 30-days to complete.
        iv. < 3-days to complete with referral to Human Resources Department (HR).
3. Identification of deficiencies may come through numerous channels, including but not limited to:
    a. Internal audits.
    b. Provider audits.
    c. Fraud, waste, and abuse audits/Program integrity audits.
    d. External audits.
    e. Investigations.
    f. Monitoring activities.
4. In the event Umpqua Health becomes aware of processes that do not align with regulatory or contractual requirements Umpqua Health's Compliance Department will assign a risk response to the appropriate party using one of the aforementioned methods. Appropriate parties may include departments or individuals.

5. The activities of a risk response will vary depending on the issue, but some items may include:
    a. Disciplinary actions.
    b. Creation or revision of a policy.
    c. Procedural changes.
    d. Training.
    e. Recoupment of funds.
6. Assignment of the type of risk response is determined by the risk impact score as determined by the Risk Response Tool (RRT) (See Sample Scenarios). The Chief Compliance Officer may, as needed, adjust the assigned risk response.
    a. Umpqua Health's RRT is based on the core elements of those used by the Federal Sentencing Guidelines (see the Risk Response Tool diagram).
    b. Issues not improved through the one risk response assignment may warrant the assignment of a higher-level risk response (e.g. opportunity plan assigned if no improvement after notice).
7. Communication with the Compliance Department is important when working on risk responses. For instance, if an unexpected barrier arises delaying the completion of a risk response, it is important to begin that discussion with Compliance as soon as it is known instead of waiting or letting the agreed upon date of completion pass.

<u>Risk Response Plan Development (OPs and CAPs)</u>

1. The department lead should work with the executive assigned to ensure that the plan addresses the identified deficiencies as well as any potential or existing barriers (including any needed resources).
2. Compliance will collaborate with the department lead assigned a risk response, to ensure that the plan will appropriately mitigate the matter. However, the prescribed actions and implementation of the risk response is solely the responsibility of the department lead and the corresponding executive assigned to the risk response.

<u>Required Status Updates (CAPs)</u>

1. The following Risk Response Tool diagram indicates which risk responses require status updates and the frequency.
    a. It is the department's responsibility to provide the following information in its update:
        i. Date of update;
        ii. Progress details of each risk response item;

iii. Any barriers encountered;
iv. Supporting documentation, as applicable; and
v. If extenuating circumstances necessitate an extension request.

b. Status updates may be provided via meetings or formal written reports. Whichever the format, updates must be provided routinely to Compliance.

2. Extensions may be requested through the status update process.
   a. The Compliance Officer will review requests and either approve or deny the extension. Compliance will then notify the requesting party.

Completion and Validation of Risk Response Plans (CAPs)

1. Upon completion of a CAP, Compliance will engage in follow-up activities to verify that the action plan appropriately addresses the deficiency. Such actions may include:
   a. Auditing.
   b. Monitoring.
2. Department leads should submit any supporting documentation that provides evidence of the CAP having been completed to Compliance. This will aid with Compliance's verification process.
   a. Documentation may be provided during status update check-ins or in between such reports if needed.
   b. Department leads do not need to wait until status update check-ins to notify Compliance that a CAP has been completed.
3. In the event a CAP does not appropriately remediate the matter or is not completed in a timely manner, the Chief Compliance Officer in consultation with members of the Executive Team (ET) and Board Oversight Compliance Committee (BOCC), may take additional actions which may include disciplinary action up to and including termination.

OHA CAP Process for Umpqua Health Alliance (UHA)

1. In the event OHA requires UHA to complete a corrective action plan UHA will work collaboratively with OHA.
   a. The development and implementation of the corrective action plan shall include, at minimum:
      i. A description of the issues and factors which contributed to the deficiency;
      ii. Designation of a person within UHA's organization charged with the responsibility of correcting the issue and ensuring there is no reoccurrence;

iii. A detailed description of the specific actions UHA will take to remedy the deficiency;
iv. A timeline for when those actions will begin and when the deficiency will be corrected, which shall not exceed 180 days from the date of the implementation of the corrective action plan, or mechanisms that are put in place to prevent a reoccurrence of the same or similar deficiency;
v. Identification of any member access to care issues that were caused as a result of the deficiency; and
vi. If the deficiency originated with a subcontractor, a description of how UHA intends to monitor subcontractor performance to prevent reoccurrence. A risk response process may be warranted to ensure proper follow through to appropriately mitigate deficiency (see section External Risk Response Process).

b. UHA will provide OHA with, as directed by OHA, a written or oral (or both) status update evidencing that the corrective action plan has been completed and that the deficiency or deficiencies have been fully and successfully corrected.
c. UHA shall provide, via Administrative Notice to OHA's Contract Administrator, all corrective action plans required to be developed and implemented, for review and approval within the time frame identified by OHA. OHA will provide, via Administrative Notice to Contractor's Contract Administrator, of approval or disapproval of the proposed corrective action plan.
    i. In the event OHA disapproves of a corrective action plan, UHA shall, in order to remedy the deficiencies in such plan, follow the process set forth in the CCO Contract.

2. These CAPs (assignment, status updates, completion, and validation) will also be tracked in the Internal Risk Response Log.

Correction or Coordination of Suspected Criminal Acts with Law Enforcement Agencies

1. See section External Reporting of the Compliance Program Manual.

Adherence to Risk Response Process

1. Failure to adhere to this policy may result in disciplinary actions as outlined in CO19 – Disciplinary Process for Compliance Infractions.

Corresponding Policy & Procedure

1. See section: External Risk Response Process

External Risk Response Process

The purpose of this policy is to outline the risk response process for external personnel and ensure proper follow through in order to appropriately mitigate the known issue.

RESPONSIBILITY

Compliance Department

PROCEDURES

General

1. In accordance with Exhibit B, Parts 2, 4, and 8 of Umpqua Health Alliance's Coordinated Care Organization (CCO) contract with the Oregon Health Authority (OHA) and 42 CFR § 438.608, Umpqua Health will engage in a multifaceted risk response process to address any deficiencies that become known to the organization.
2. Umpqua Health's risk response process is a multilayered approach to ensure deficiencies are swiftly rectified. Mitigation of identified deficiencies may be dealt with in using the following means:
    a. Notice of Opportunity (Notice).
    b. Opportunity Plan (OP).
        i. 180 days to complete.
    c. Corrective Action Plan (CAP).
        i. 90-days to complete.
        ii. 60-days to complete.
        iii. 30-days to complete.
        iv. < 3-days to complete with contract review.
3. Identification of deficiencies may come through numerous channels, including but not limited to:
    a. Provider audits.
    b. Program integrity audits.
    c. External audits.
    d. Subcontractor audits.
    e. Investigations.
    f. Monitoring activities.
    g. Quality Improvement Committee reviews.
4. In the event Umpqua Health becomes aware of processes that do not align with regulatory or contractual requirements Umpqua Health's Compliance Department will assign a risk response to the appropriate party using one of the aforementioned methods.

Appropriate parties may include independent contractors, subcontractors, network providers or other external personnel.

5. The activities of a risk response will vary depending on the issue, but some items may include:
    a. Disciplinary actions.
    b. Creation or revision of a policy.
    c. Procedural changes.
    d. Training.
    e. Recoupment of funds.
6. Assignment of the type of risk response is determined by the risk impact score as determined by the Risk Response Tool (RRT). The Compliance Officer may, as needed, adjust the assigned risk response.
    a. Umpqua Health's RRT is based on the core elements of those used by the Federal Sentencing Guidelines (see the Risk Response Tool diagram).
    b. Issues not improved through the one risk response assignment may warrant the assignment of a higher level risk response (e.g. opportunity plan assigned if no improvement after notice).
7. Communication with the Compliance Department is important when working on risk responses. For instance, if an unexpected barrier arises delaying the completion of a risk response, it is important to begin that discussion with Compliance as soon as it is known instead of waiting or letting the agreed upon date of completion pass.
8. The Compliance Department upon assigning a risk response to any UHA external personnel will provide a copy to UHA's Quality Improvement Committee.

<u>Risk Response Plan Development (OPs and CAPs)</u>

1. The assigned party needs to ensure that the developed plan addresses the identified issues as well as any potential or existing barriers (including any needed resources).
2. Compliance will collaborate with the assigned party, to ensure that the plan will appropriately mitigate the matter. However, the prescribed actions and implementation of the risk response is solely the responsibility of the party assigned to the risk response.

<u>Required Status Updates (OPs & CAPs)</u>

1. The following Risk Response Tool diagram indicates which risk responses require status updates and the frequency (i.e. Opportunity Plans and Corrective Action Plans).
    a. It is the party's responsibility to provide the following information in its update:
        i. Date of update;

ii. Progress details of each risk response item;
iii. Any barriers encountered;
iv. Supporting documentation, as applicable; and
v. If extenuating circumstances necessitate an extension request.

b. Status updates may be provided via meetings or formal written reports. Whichever the format, updates must be provided routinely to Compliance.
c. Status updates for risk responses assigned to UHA external personal will be shared with UHA's Quality Improvement Committee.

2. Extensions may be requested through the status update process.
    a. The Compliance Officer will review requests and either approve or deny the extension. Compliance will then notify the requesting party.

Completion and Validation of Risk Response Plans (CAPs)

1. Upon completion of a CAP, Compliance will engage in follow-up activities to verify that the action plan appropriately addresses the deficiency. Such actions may include:
    a. Auditing.
    b. Monitoring.
2. External parties should submit any supporting documentation that provides evidence of the CAP having been completed to Compliance. This will aid with Compliance's verification process.
    a. Documentation may be provided during status update check-ins or in between such reports if needed.
    b. Parties do not need to wait until status update check-ins to notify Compliance that a CAP has been completed.
3. In the event a CAP does not appropriately remediate the matter or is not completed in a timely manner, the Compliance Officer in consultation with members of the Executive Team (ET) and Board Oversight Compliance Committee (BOCC), may take additional actions which may include disciplinary action such as contract review, sanctions or termination.

External Personnel CAPs and Umpqua Health Alliance (UHA)

1. When a subcontractor delegated work on behalf of UHA is found to have deficiencies necessitating a CAP, the OHA will be engaged.
2. A copy of the CAP will be provided to OHA via Administrative Notice and the Quality Improvement Committee documenting the following:
    a. Deficiencies;

   b. Actions required; and
   c. Timeframe to be completed.
3. The provided notice will be given to OHA no more than 14-days after providing the CAP to the subcontractor.
4. External personnel are to ensure status updates are provided timely and are submitted to UHA no later than the assigned due date. UHA is required under the CCO Contract to submit CAP updates to OHA on the status and process of the assigned CAP.
   a. In the event external personnel demonstrate multiple occurrences of untimely CAP updates, UHA may assess financial penalties if external personal are found to be in breach of contract.
5. No more than 14-days after the stated timeframe of completion, OHA, via Administrative Notice, will be provided an update. The update will include whether the CAP was successfully completed or if the underlying deficiency still remains.
6. These CAPs (assignment, status updates, completion, and validation) will also be tracked in the Subcontractor Risk Response Log.

Correction or Coordination of Suspected Criminal Acts with Law Enforcement Agencies

1. See section External Reporting of the Compliance Program Manual.

Adherence to Risk Response Process

1. Failure to adhere to this policy may result in review of contract, sanctions, and/or termination.

Corresponding Policy & Procedure

1. See section: Internal Risk Response Process

Risk Assessment and Annual Compliance & FWA Prevention Program

Annually, or more frequent if needed, Umpqua Health conducts an organizational wide Risk Assessment to identify the risks that may affect the organizations. The Risk Assessment also assesses the necessary modifications needed in its Compliance and FWA Prevention Program. At the conclusion of the Risk Assessment, an Annual Compliance & FWA Prevention Work Plan is developed to lay out the strategies and activities for how the organization will combat and mitigate risks, along with the necessary refinements to Umpqua Health's Compliance and FWA Prevention Program. The Compliance and FWA Prevention Work Plan is a living document that is reviewed and revised throughout the contract year with any new compliance or PI activity identified. Lastly, Umpqua Health's Board Oversight Compliance Committee may seek an evaluation of the organization's Compliance and FWA Prevention Program. Items identified in this process will be included in that year's Annual Compliance and FWA Prevention Work Plan for mitigation. (See Fraud, Waste, and Abuse Prevention Handbook).

Subcontractors

Umpqua Health Alliance (UHA), its parent company Umpqua Health, along with Umpqua Health Network (UHN), endeavor to provide members with the high-quality network by complying with OAR 410-141-4505 and Exhibit B, Part 4, Section 11(a) and (b) of the CCO between UHA and OHA.

Umpqua Health is ultimately responsible for the activities and performance of its first tier, downstream, and related entities (FDR) and subcontractors. Accordingly, Umpqua Health is required to engage in routine monitoring of these entities to validate performance alignment with the contractual and legal requirements Umpqua Health is required to perform.

The purpose of these policies is to outline the general and written agreement requirements for engaging subcontractors for tasks related to UHA under the CCO Contract with OHA and to discuss the process for monitoring and evaluation of FDR and/or subcontractors during the contractual relationship.

RESPONSIBILITY

Executive Team
Compliance Department
Contracting Department
Provider Network
Quality Improvement
Quality Improvement Committee

Evaluation of Subcontractor

PROCEDURES

1. In accordance with the CCO Contract, Exhibit B, Part 4, Section 11, 42 CFR §§ 438.230 and 422.504, Umpqua Health is ultimately responsible for any function that is delegated to a direct FDR and/or subcontractor.
    a. UHA will only delegate activities to subcontractors if not prohibited from doing so in the CCO Contract. As such the following will not be delegated:
        i. Oversight and monitoring of quality improvement activities; and
        ii. Adjudication of appeals in the UHA Grievance and Appeal process.
2. Any current or potential direct FDR and/or subcontractor is required to fully comply and cooperate with any review conducted by Umpqua Health to verify that the delegate has the necessary processes to support the delegated functions.
3. Prior to engaging in a FDR/sub contractual relationship (direct), any individual or entity will be screened for exclusion from participation in Federal programs. In the event the party is found to be excluded, no relationship shall be established, and the party shall be

reported to the Department of Health and Human Services and the Office of Inspector General and OHA.

4. Umpqua Health and the direct FDR and/or subcontractor will establish a contractual relationship that outlines the activities delegated to the FDR or subcontractor (see sections Subcontractor – General Requirement Standards and Subcontractor – Written Agreement Requirement Standards).
    a. Delegated arrangements must contain the required OHA subcontractor provisions and Medicare delegation provisions.
    b. Arrangements should contain expectations for pre-assessment, routine monitoring, and assessment participation, along with remediation and financial penalty/sanction language, in the event the FDR/subcontractor is not performing in accordance with its contract.
5. Umpqua Health's Executive Team will assign a subcontractor contact lead who will be responsible in the overall oversight of the FDR or subcontractor. That individual will coordinate with the Compliance Department and Quality Improvement Committee to ensure appropriate monitoring, pre-assessment, and annual assessments are established.

<u>Proposed UHA Direct FDR/Subcontracts</u>

1. At the time the subcontract is proposed, UHA must provide to OHA the "Subcontractor and Delegated Work Report" documenting, in list form, all activities required to be performed under the CCO Contract that are to be delegated to a subcontractor, subcontracted by a subcontractor to a downstream entity, or any combination thereof. The report will identify the downstream entity ultimately performing the work or other activities required to be performed under the CCO Contract, regardless of the tiers of subcontracts that exist between UHA and that downstream entity.
2. This report shall be provided to OHA no later than March 1st of each contract year and within 30 days after there has been any change in a subcontractor. The Subcontractor and Delegated Work Report must also include:
    a. The legal name of each direct or indirect subcontractor;
    b. The scope of work or activities (or both) being subcontracted to each direct or indirect subcontractor;
    c. The current risk level of each direct subcontractor (high, medium, low) as determined by UHA or direction provided by OHA based on the Subcontractor and Delegated Work Report.
        i. Assigned risk level is based on:

1. The work delegated to the subcontractor and the level of member impact such delegated work may have.
2. The results of any previous Subcontractor Performance Report(s),
3. Any other factors deemed applicable by UHA or OHA or any combination thereof.

ii. UHA must apply the high-risk criteria (see definition) established by OHA to any subcontractor identified in its Subcontractor and Delegated Work Report that meets the criteria.

d. Copies of ownership disclosure form, if applicable for each direct subcontractor;
e. Copies of all written agreements with subcontractors to ensure all contracts meet the requirements outlined in 42 CFR § 438.230; and
f. Any ownership stake between UHA and each direct subcontractor.
g. Attestation that UHA has:
    i. Conducted a readiness review of each direct subcontractor, unless UHA relied on the subcontractor's readiness review required by Exhibit B, Part 4, Section 11(a)(4) or Medicare or UHA previously conducted a readiness review for subcontractor's work performed under the CCO Contract within the last three (3) years.
    ii. Confirmed that each direct subcontractor was and is not excluded from participation in federal program.
    iii. Confirmed all direct subcontractor employees are subject to, and have undergone, criminal background checks.
    iv. The written subcontract entered with the direct subcontractor meets all of the requirements set forth in Exhibit B, Part 4. And other applicable provision of the CCO Contract.
    v. Conducted formal compliance and performance review of each direct subcontractor consistent with Exhibit B, Part 4, Section 11(a)(13).

<u>Pre-Assessment</u>

1. Prior to delegating any function to a direct FDR/subcontractor, Umpqua Health must conduct a pre-assessment to determine the FDR/subcontractor readiness for delegation.
    a. Direct subcontractors wanting to engage in a relationship with UHA, will have a pre-assessment readiness review conducted as stipulated in the CCO Contract.
        a. Copies of completed readiness review evaluations of each and every direct subcontractor shall be provided, via Administrative Notice, to OHA's Contract Administrator within five (5) business days after request by OHA.

b. If UHA has a contract with a prospective subcontractor that involves performance of services on behalf of UHA for a Medicare Advantage plan operated by UHA or its parent company Umpqua Health or subsidiary, UHA may satisfy the requirements of the above Pre-Assessment(1)(a) by submission of the results of its subcontractor readiness review evaluation required by Medicare, but only for:
    a. Work identical to what is being subcontracted under the CCO Contract and
    b. Only if the Medicare readiness review has been completed no more than six (6) months prior to the effective date of the prospective subcontract.

2. For direct subcontractors, prior to delegating any function to a subdelegate, the subcontractor must obtain prior consent from UHA for certain delegated functions as described in the subcontract. If consent is granted, the direct subcontractor must conduct a pre-assessment to determine the subdelegate's readiness for delegation.
    a. The pre-delegation assessment must be submitted to UHA for approval before delegated functions are assigned.
3. Such pre-assessment activities may include, but are not limited to:
    a. Policy and procedure review.
    b. System review.
    c. Onsite review.
    d. Review of files.
4. In the event the pre-assessment review, conducted by UHA or the direct subcontractor, determines that the FDR/subcontractor is not ready for delegation, Umpqua Health has the obligation to ensure the delegated functions are not delegated until those functions can be appropriately completed.
5. Depending on the outcome of the pre-assessment review, Umpqua Health may elect to do the following:
    a. Delay delegation until a risk response plan has been implemented.
    b. Terminate delegated relationship.
    c. Proceed with delegation as planned while a concurrent risk response plan is implemented.
    d. Proceed with delegation as planned.

<u>Routine Monitoring</u>

1. During the contracting process, Umpqua Health will establish routine monitoring activities and reports that the FDR/subcontractor will be required to submit on a periodic basis.

a. These reports should be tied to and demonstrate the activities delegated to the FDR or subcontractor.

2. FDR and subcontractors who consistently perform below its required performance will be required to complete a risk response plan to address the matter (see section: External Risk Response Process).

Subcontractor Evaluation, General

1. Annually, Umpqua Health or its direct subcontractor will conduct timely comprehensive assessment of their direct FDR/subcontractor's performance.
2. The scope of the assessment may vary slightly but should primarily focus on the following elements:
    a. Contract between Umpqua Health and the direct FDR or subcontractor.
    b. State, Federal, and/or contractual requirements.
3. Deficiencies identified during the annual evaluation process will result in a risk response plan that will need to be completed by the FDR or subcontractor (see section: External Risk Response Process).

Subcontractor Evaluation, UHA Subcontracts

1. In addition to the aforementioned general elements, for UHA subcontractors the following elements will also be included:
    a. An assessment for the purpose of evaluating the quality of subcontractor's performance of contracted work;
    b. Any complaints or grievances filed in relation to subcontractor's work;
    c. Any late submission of reporting deliverables or incomplete data;
    d. Whether employees of the subcontractor are screened and monitored for Federal exclusion from participation in Medicaid;
    e. The adequacy of Subcontractor's compliance functions; and
    f. Any deficiencies that have been identified by OHA related to work performed by subcontractor.
2. UHA shall conduct annual Subcontractor Performance Reviews for high risk subcontractors and every three (3) years for low or medium risk subcontractors. UHA shall oversee and be responsible for the satisfactory performance of any functions or responsibilities it has delegated to a direct subcontractor.
    a. UHA will document in the Subcontractor Performance Report its conclusion as to whether its subcontractor has complied with all the terms and conditions of the

CCO Contract that are applicable to the work performed by the subcontractor no later than December 31 of the current contract year in which the report is due.

b. For high-risk subcontractors, UHA shall provide OHA, via OHA's Contract Administrator, with a copy of the Subcontractor Performance Report (or the substituted Medicare Compliance Review) within 30 days of completion:
c. Pursuant to 42 CFR § 438.608, to the extent that UHA subcontracts to any third parties any responsibility for providing services to members or processing and paying for claims, require such subcontractors to adopt and comply with all of UHA's Fraud, Waste, and Abuse (FWA) policies, procedures, reporting obligations, and annual Compliance and FWA Prevention Program and otherwise require subcontractor to comply with and perform all of the same obligations, terms and conditions of UHA as set forth in Exhibit B, Part 9.

3. Pursuant to 42 CFR § 438.608, to the extent that UHA subcontracts to any third parties any responsibility for providing services to members or processing and paying for claims, UHA requires such subcontractors to adopt and comply with all of UHA's Fraud, Waste, and Abuse (FWA) policies, procedures, reporting obligations, and annual Compliance and FWA Prevention Program and otherwise require subcontractor to comply with and perform all of the same obligations, terms and conditions of UHA as set forth in Exhibit B, Part 9.

<u>Risk Response Plan, General</u>

1. At any point during the contractor relationship, Umpqua Health may require the FDR or subcontractor to complete a risk response plan to mitigate any deficiencies.
2. Umpqua Health may prescribe a timeline for when the FDR or subcontractor needs to implement the risk response plan.
3. In the event the FDR or subcontractor fails to meet this timeline or does not implement an appropriate risk response plan (determined by Umpqua Health), Umpqua Health may take additional sanctions including financial penalties (if allowed) and/or termination of the contractual relationship.

<u>Risk Response Plan, UHA FDR/Subcontractors</u>

1. In the event UHA identifies deficiencies or areas for improvement whether through ongoing monitoring or formal annual compliance review that warrant a corrective action plan, UHA will require subcontractor to take corrective action to complete Risk Response Plan (see section: External Risk Response Plan).

Subcontractor – General Requirement Standards

PROCEDURES

In no event shall UHA delegate, or otherwise assign to third parties, the responsibility for performing any work required under the CCO Contract, without first entering into a subcontract that complies with the terms and conditions of the CCO Contract. In all such instances, UHA shall, at a minimum, include all of the following standards, terms, and conditions in all of its subcontracts:

1. To the extent UHA subcontracts any services or obligations to a direct subcontractor, subcontractor must perform the services and meet the obligations and terms and conditions as if the subcontractor is UHA.
2. UHA shall ensure that all subcontracts (see section: Subcontractor – Written Agreement Requirement Standards for additional details):
    a. Are in writing;
    b. Specify the subcontracted work and reporting responsibilities;
    c. Capture subcontractor's agreement to perform delegated duties and any reporting responsibilities;
    d. Are in compliance with the requirements described Exhibit B, Part 4, Section 11 of the CCO Contract as well as any other contract; and
    e. Incorporate the applicable provisions of the CCO Contract, based on the scope of work subcontracted such that the provisions of the subcontract are the same as or substantively similar to the applicable provisions of the CCO Contract.
3. UHA as a covered entity ensures it will enter into a Business Associate Agreement (BAA) with its subcontractors when required under, and in accordance with, HIPAA.
4. UHA must evaluate and document all prospective subcontractors' readiness and ability to perform the scope of work set forth in the applicable subcontract prior to the effective date of the subcontract. OHA shall have the right to request, and UHA shall provide within five (5) days after request by OHA, all readiness review evaluations (see section Evaluation of Subcontractor). If UHA has a contract with a prospective subcontractor that involves performance of services on behalf of UHA for a Medicare Advantage plan operated by UHA or its parent company or subsidiary, UHA may satisfy the requirements of Exhibit B, Part 4, Section 11(a)(4) by submitting the results of its subcontractor readiness review evaluation required by Exhibit B, Part 4, Section 11(a)(4) or Medicare, but only for work identical to that to be subcontracted under the CCO Contract and only if the readiness review has been completed no more than three years prior to the effective date of the prospective subcontract.

5. UHA shall ensure that all direct subcontractors are screened for exclusion from participation in Federal programs. In the event a subcontractor is so excluded, UHA is prohibited from subcontracting to such subcontractor any work or obligations required to be performed under the CCO Contract (see Fraud, Waste, and Abuse Prevention Handbook and see Compliance Program Manual sections: Screening of Individuals and Providers, and Evaluation of Subcontractor).
6. UHA shall ensure that all direct subcontractors and their employees undergo a criminal background check prior to starting any work identified in the CCO Contract.
    a. In the case of providers, each shall also be verified as enrolled with the State as consistent with Medicaid provider disclosure screening and enrollment requirements (42 CFR § 438.602(b)(1), CCO Contract Exhibit B, Part 4, Section 4(b)).
7. UHA shall not have the right to subcontract certain obligations and work required to be performed under the CCO Contract. Work, activities, and other obligations that UHA shall not subcontract are identified throughout the CCO Contract. Subject to the provisions of Exhibit B, Part 4, Section 11, UHA may subcontract obligations and work required to be performed under the CCO Contract that is not expressly identified as an exclusion. In accordance with 42 CFR §438.230(b)(1), no subcontract may terminate or limit UHA's legal responsibility to OHA for the timely and effective performance of UHA's duties and responsibilities under the CCO Contract.
8. UHA shall provide to OHA via Administrative Notice, a Subcontractor and Delegated Work Report in which UHA shall summarize in list form all work and other activities required to be performed under the CCO Contract that have been subcontracted to a subcontractor, subcontracted by a subcontractor to a downstream entity, or any combination thereof. In the report, UHA will identify the downstream entity ultimately performing the work or other activities required to be performed under the CCO contract, regardless of the tiers of subcontracts that exist between UHA and that downstream entity (see section: Evaluation of Subcontractor). The Subcontractor and Delegated Work Report must be provided to OHA by no later than March 1st of each contract year and within 30 days after there has been any change in a subcontractor. The Subcontractor Assignment Report shall also include all of the following:
    a. The legal name of each direct or indirect subcontractor;
    b. The scope of work or other activities (or both) being subcontracted to each direct or indirect subcontractor;
    c. The current risk level of each direct subcontractor (High, Medium, Low) determined by UHA.

i. Assigned risk level is based on:
    1. The work delegated to the Subcontractor and the level of member impact such delegated work may have.
    2. The results of any previous Subcontractor Performance Report(s),
    3. Any other factors deemed applicable by UHA or OHA or any combination thereof.
ii. UHA must apply the high-risk criteria (see definition) established by OHA to identify a subcontractor meeting such criteria.

d. Copies of ownership disclosure form, if applicable for each direct subcontractor;
e. Any ownership stake between UHA and each direct subcontractor; and
f. An attestation that UHA:
    i. Conducted a readiness review of each direct subcontractor, unless UHA relied on the subcontractor's readiness review required by Exhibit B, Part 4, Section 11(a)(4) or Medicare or UHA previously conducted a readiness review for subcontractor's work performed under the CCO Contract within the last three (3) years;
    ii. Confirmed that each direct subcontractor was and is not excluded from participation in federal program;
    iii. Confirmed all direct subcontractor employees are subject to, and have undergone, criminal background checks;
    iv. That the written subcontract entered into with the direct subcontractor meets all of the requirements set forth in the CCO Contract; and
    v. Conducted a formal compliance and performance review of each direct subcontractor consistent with Exhibit B, Part 4, Section 11(a)(13).

9. UHA shall not subcontract anything identified in the CCO Contract as prohibited from delegation, including:
    a. Oversight and monitoring of quality improvement activities; and
    b. Adjudication of appeals in a member grievance and appeal process.
10. If deficiencies are identified in subcontractor performance for any functions outlined in the CCO Contract, whether those deficiencies are identified by UHA, by OHA, or their designees, UHA agrees to require its subcontractor to respond and remedy those deficiencies within the timeframe determined by OHA. Such obligations and timeframes shall be included in all subcontracts.
    a. In the event OHA does not prescribe a remediation timeframe, UHA shall. UHA shall follow the procedures laid out in section External Risk Response Process for external personnel which addresses subcontractors.

11. UHA shall ensure that its subcontractors contracts with providers prohibit providers from billing members for services that are not covered under the CCO Contract unless there is a full written disclosure or waiver (also referred to as an agreement to pay) on file, signed by the member, in advance of the services being provided, in accordance with OAR 410-141-3565(5).
12. In accordance with Exhibit I of the CCO Contract, UHA shall provide every subcontractor, at the time it enters into a subcontract, its OHA-approved written procedures for its Grievance and Appeal System (PN6 – Provider Orientation & Training). UHA shall ensure that its subcontractors provide copies of the same written procedures to every provider contracted by the subcontractor.
13. UHA shall monitor the performance of all subcontractors on an ongoing basis and perform, timely formal reviews of their compliance of all subcontracted obligations and other responsibilities, for the purpose of evaluation their performance, which must identify any deficiencies, and areas for improvement. Such reviews shall be documented in Subcontractor Performance Report. UHA shall make a conclusion in each Subcontractor Performance Report as to whether a subcontractor has complied with all the terms and conditions of the CCO Contract that are applicable to the work performed by subcontractor (see section: Evaluation of Subcontractor).
    a. Subcontractor Performance reviews are timely when conducted in accordance with the following schedule:
        i. A high-risk subcontractor must be reviewed at least annually.
        ii. A low or medium risk subcontractor must be reviewed at least every three (3) years.
14. Umpqua Health Alliance staff must utilize the Compliance Department's Subcontractor Performance Report Template which aligns with the guidance document provided by OHA. The guidance document can be found on the CCO Contract Forms website.
    a. The Annual Subcontractor Performance Report must include at a minimum the following elements:
        i. An assessment of the quality of subcontractor's performance of contracted work;
        ii. Any complaints or grievances filed in relation to subcontractor's work;
        iii. Any late submission of reporting deliverables or incomplete data;
        iv. Whether employees of the subcontractor are screened and monitored for federal exclusion from participation in Medicaid;
        v. The adequacy of subcontractor's compliance functions; and

15. Any deficiencies that have been identified by OHA related to work performed by subcontractor. If UHA has subcontracted for services under a Medicare Advantage plan operated by UHA or its parent company or subsidiary, UHA may satisfy the requirements of Exhibit B, Part 4, Section 11(a)(13) and (14) by submitting the results of its Medicare required subcontractor compliance review ("Medicare Compliance Review"), provided that
    a. The work performed by such subcontractor was identical to the work subcontracted under the CCO Contract, and
    b. The time period for the Medicare Compliance Review is identical to or includes the same time period for the Annual Subcontractor Performance Report required to be submitted under the CCO Contract.
16. For each high-risk subcontractor, UHA shall provide a copy of the Annual Subcontractor Performance Report (or the substituted Medicare Compliance Review) to OHA via Administrative Notice, within 30 days of completion and no later than December 31st of the contract year in which the report is to be completed. UHA shall oversee and be responsible for the satisfactory performance of any functions or responsibilities it has delegated to a subcontractor (see section: Evaluation of Subcontractor)
    a. For each low or medium risk subcontractor, UHA will provide a copy of the Subcontractor Performance Report (or the substituted Medicare Compliance Review) to OHA upon request, via Administrative Notice, within five (5) business days after request by OHA. UHA will oversee and be responsible for the satisfactory performance of any functions or responsibilities it has delegated to a subcontractor.
17. In the event UHA identifies, whether through ongoing monitoring or formal annual compliance review, deficiencies or areas for improvement in a subcontractor's performance, UHA has a multilayered approach to ensure deficiencies are swiftly rectified. If a corrective action plan is determined necessary, UHA shall cause subcontractor to take corrective action see sections Evaluation of Subcontractor and External Risk Response Process).
    a. In addition, UHA shall provide, via Administrative Notice (deliverable portal), to OHA's Contract Administrator with a copy of the corrective action plan (CAP) documenting the deficiencies, actions required of the subcontractor to remedy the deficiencies, and the time frame for completing such required actions. The foregoing Administrative Notice shall be made within 14 days after providing the CAP to the applicable subcontractor.
    b. UHA shall provide OHA with an update on the status of the CAP at such time that the subcontractor has been successfully removed from CAP or, of the

subcontractor's failure to fully remedy the underlying deficiency, if the deadline for such remedy has passed. Such update shall be provided to OHA via Administrative Notice within 14 days after the intended original completion date set forth in the applicable CAP.

Subcontractor – Written Agreement Requirement Standards

PROCEDURES

In no event shall UHA delegate, or otherwise assign to third parties, the responsibility for performing any work required under the CCO Contract without first entering into a subcontract that complies with the terms and conditions of the CCO Contract (see – Subcontractor – General Requirement Standards).

General Elements

1. In addition to the contract requirements described in the Specific Requirements section of this policy and those outlined in section Subcontractor – General Requirement Standards, every contract will illustrate:
    a. Delegated activities or obligations;
    b. Reporting responsibilities;
    c. The subcontractor's agreement to perform delegated activities and reporting responsibilities; and
    d. The obligations and timeframes for remedying deficiencies in subcontractor's performance.

Specific Requirements

In all such instances, UHA shall, at a minimum, include all of the following standards, terms, and conditions in all of its subcontracts written agreements:

1. Provide for termination of the subcontract, the right to take remedial action, and impose other sanctions by UHA, such that UHA's rights substantively align with OHA's rights under the CCO Contract, if the subcontractor's performance is inadequate to meet the requirements of the CCO Contract;
2. Provide for revocation of the delegation of activities or obligations, and specify other remedies in instances where OHA or the UHA determine the subcontractor has breached the terms of the subcontract;
3. Require subcontractor to comply with the payment, withholding, incentive and other requirements set forth in 42 CFR § 438.6 that are applicable to the work required under the subcontract;
4. Require subcontractors to submit to UHA valid claims for services including all the fields and information needed to allow the claim to be processed without further information from the provider within timeframes for valid, accurate, encounter data submission as required under Exhibit B, Part 8 and other provisions of the CCO Contract;

5. An express statement whereby subcontractor agrees to comply with all applicable laws, including, without limitation, all Medicaid laws, rules, regulations, as well as all applicable sub-regulatory guidance and contract provisions;
    a. Subcontractors agree to comply with Section C Part 10 of Attachment I of the 2017-2022 Medicaid 1115 Waiver regarding timely Payment to IHCP Providers;
    b. Timely payments means that Indian Health Care Providers (IHCPs) must be paid the agreed upon rate within 30-90 calendar days of billing;
    c. Subcontractor agrees to perform any activities necessary to support UHA and the Authority's obligations as specified in the CCO Contract, state law, and federal law, including requirements related to:
        i. Program integrity and data submission, including the requirements in 42 CFR, Part 438, Subpart H;
        ii. Grievances and appeals, including the requirements in 42 CFR, Part 438, Subpart F;
        iii. Exclusions, as noted in 42 CFR § 438.808; and
        iv. Linguistic and disability access for members, as outlined in 42 CFR § 438.10, as well as 42 U.S.C. § 18116 and 45 CFR Part 92.
6. An express statement whereby subcontractor agrees that OHA, the Oregon Secretary of State, Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services (DHHS), the Office of the Inspector General (OIG), the Comptroller General of the United States, or their duly authorized representatives and designees, or all of them or any combination of them, have the right to audit, evaluate, and inspect any books, records, contracts, computers or other electronic systems of the Subcontractor, or of the subcontractor's UHA, that pertain to any aspect of services and activities performed, or determination of amounts payable under the CCO Contract;
7. Specify that the subcontractor will make available, for purposes of audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid members;
8. Specify that the subcontractor must respond and comply in a timely manner to any and all requests from OHA or its designee for information or documentation pertaining to work outlined in the CCO Contract;
9. Specify that the subcontractor agrees that the right to audit by OHA, CMS, the DHHS Inspector General, the Comptroller General or their designees, will exist for a period of ten (10) years from the CCO Contract's expiration date or from the date of completion of any audit, whichever is later; and

10. Specify that if OHA, CMS, or DHHS-OIG determine that there is a reasonable possibility of fraud or similar risk, OHA, CMS, or the DHHS-OIG may inspect, evaluate, and audit the subcontractor at any time.
11. Pursuant to 42 CFR § 438.608, to the extent that UHA subcontracts to any third parties any responsibility for providing services to members or processing and paying for claims, require such subcontractors to adopt and comply with all of UHA's Fraud, Waste, and Abuse (FWA) policies, procedures, reporting obligations, and annual Compliance and FWA Prevention Program and otherwise require subcontractor to comply with and perform all of the same obligations, terms and conditions of UHA as set forth in Exhibit B, Part 9.
    a. Unless expressly provided otherwise in the applicable provision, subcontractors must report any provider and member FWA to UHA which UHA will in turn report to OHA or the applicable agency, division, or entity. Accordingly, the timing for reporting obligations of subcontractor must be shorter than those of UHA's time for reporting to OHA so that UHA may timely report such incidents to OHA in accordance with the CCO Contract.
12. Require subcontractor to:
    a. Follow OAR 410-141-3520(1) record keeping system must ensure the security of its records, including clinical records that document the covered services provided to members, as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing HIPAA.
    b. Maintain written policies and procedures regarding the access, use, and transmission of records that comply with ORS 413.171, OAR 943-014-0300 through 943-014-0320, OAR 943-120-0000 through 943-120-0200, and Exhibit B, Part 8 of the CCO Contract.
    c. Allow OHA to monitor compliance with subcontractor's records security policies.
13. Require subcontractors to allow UHA to perform monitoring, audit, and other review processes for the purpose of determining and reporting on compliance with the terms and conditions of the subcontract, including, without limitation, compliance with medical and other records security and retention policies and procedures (see section Evaluation of Subcontractor).
    a. UHA must document and maintain all monitoring activities.
14. Require subcontractors to require any contracted providers to meet, the standards for timely access to care and services as set forth in the CCO Contract and OAR 410-141-

3515, which includes, without limitation, providing services within a time frame that takes into account the urgency of the need for services.

15. Require subcontractors to report any other primary, third-party insurance to which a member may be entitled. Providers and subcontractors must report such information to UHA within a timeframe that enables UHA to report such information to OHA within 30 days of the Subcontractor becoming aware that the applicable member has such coverage, as required under Exhibit B, Part 8, Section 17 of the CCO Contract.
16. Require subcontractors to provide, in a timely manner upon request, as requested by UHA in accordance with the request made by OHA, or as may be requested directly by OHA, with all Third-Party Liability (TPL) eligibility information and any other information requested by OHA or UHA, as applicable, in order to assist in the pursuit of financial recovery.
17. In the event UHA issues or receives notice that a subcontractor's subcontract has been terminated, and that subcontractor providers covered service to members including but not limited to in the capacity of participating providers, UHA shall provide, written notice, translated as appropriate, of such termination to members who receive covered services from the subcontractor as follows:
    a. At least 30 days prior to the effective date or termination; or
    b. within 15 days after receipt or issuance of the termination notice, if the subcontractor has not given UHA sufficient notification to meet the 30-day notice requirement.
18. UHA shall have 30 days to provide OHA with Administrative Notice that:
    a. It has terminated a subcontractor; or
    b. A subcontractor has terminated its subcontract with UHA. Such Administrative Notice shall also include an updated Subcontractor and Delegated Work Report.
19. Subcontractors must document, maintain, and provide to UHA all encounter data records that document subcontractor's reimbursement to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and IHCPs. All such documents and records must be provided to UHA upon request of UHA (who will in turn provide it to OHA).
20. UHA understands and agrees that if UHA is not paid or not eligible for payment by OHA for services provided, neither will UHA's subcontractors be paid or be eligible for payment.
21. Within two (2) business days after receipt of a written request from OHA, UHA shall provide OHA with any and all copies of subcontracts entered into by UHA that relate to services required to be provided under the CCO Contract. Additionally, within five (5) business days after receipt of a written request from OHA, UHA shall provide OHA with

any and all copies of subcontracts entered into by UHA's subcontractor(s) that related to the services required to be provided under the CCO Contract. OHA will make its requests for the applicable subcontracts via administrative notice, and UHA will provide such subcontracts to OHA in the manner directed by OHA in the applicable request.