Fraud, Waste, and Abuse (FWA) Prevention Handbook

Policies and Procedures

Approved by the Board Oversight Compliance Committee
January 27, 2026

Contents

Introduction

Umpqua Health Alliance (UHA) is committed to operating in compliance with applicable federal and state laws, regulations, and contractual requirements. Because UHA operates in a heavily regulated environment and across multiple lines of business, UHA prioritizes and maintains a robust Compliance and Fraud, Waste, and Abuse (FWA) Prevention Program.

To support the effectiveness of this program, Umpqua Health Management (UHM) is responsible for developing, maintaining, and updating UHA's policies, procedures, and Compliance and FWA Prevention Program.

UHM has developed this FWA 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 and detection activities, data processing, claims payment, records maintenance, and other services.
- **Umpqua Health Newton Creek (UHNC)**: 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

The FWA Prevention Handbook, in conjunction with the Compliance Program Manual, was developed by UHM's Compliance Department, with approval from the Board Oversight Compliance Committee and Board of Directors. This Handbook establishes the operational procedures for fraud, waste, and abuse prevention, detection, investigation, and response and serves as the primary procedural resource for these activities. It implements the governance framework and oversight requirements set forth in the Compliance Program Manual. The Compliance Officer ensures the FWA Prevention Handbook 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.

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

1. UHA Health Plan Services contract ("CCO contract") with the Oregon Health Authority: Exhibit B, Part 9, Sections 1 - 20.

2. Oregon Administrative Rules (OAR): OAR 410-120-1510, OAR 410-141-3520, and OAR 410-141-3625.
3. Code of Federal Regulations (CFR): 42 CFR § 433.116; 42 CFR §§ 438.214, 438.600–438.610, and 438.808; 42 CFR §§ 455.20 and 455.104–455.106; 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).

The FWA Prevention Handbook operates under the framework of the "Seven Elements of a Successful Compliance Program," as identified by the U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG) and outlines how UHA meets the contractual obligations listed above through its FWA Prevention Program. Furthermore, the FWA Prevention Program provides a framework of how Umpqua Health safeguards against fraud, waste, and abuse for the entire organization, including its government-supported programs, UHA and P3/ATRIO through its Master Service Agreement. This FWA Prevention Handbook applies to all internal and external personnel.

Definitions

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the organization and 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 (Title 42 Code of Federal Regulation (CFR) § 455.2 and Oregon Administrative Rules (OAR) 410-120-0000(1)).

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).

Billing Provider (BP): An individual, agent, business, corporation, clinic, group, institution, or other entity who submits claims to or receives payment from the Division on behalf of a rendering provider and has been delegated the authority to obligate or act on behalf of the rendering provider (Oregon Administrative Rule (OAR) 410-120-0000).

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.

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 assigned the overall responsibility of overseeing the risk response process to resolve the matter(s).

Designated Health Services: Items and services designated by the Centers for Medicare and Medicaid Services which include clinical laboratory services; physical therapy services, occupational therapy services, outpatient speech-language pathology services; radiology and certain other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

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.

Financial Relationship: An ownership or investment interest in the entity, or a compensation arrangement with the entity.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an 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).

Fraud, Waste, and Abuse (FWA) Investigation: A systematic review conducted to detect and prevent fraudulent, wasteful, or abusive practices within UHA and UHM. This audit can involve examining financial transactions, claims, billing practices, and operational procedures to identify irregularities, discrepancies, or non-compliance with legal and regulatory standards. The primary objective is to ensure integrity, efficiency, and accountability in the use of resources and to safeguard against improper practices that could result in financial loss or harm to stakeholders. A FWA Investigation is distinct from a Program Integrity Audit and is typically used to determine whether sufficient cause exists to initiate a formal audit or referral.

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

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).

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

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

Overpayment: Any payment made to a network provider by an MCO, PIHP, or PAHP to which the network provider is not entitled to under Title XIX of the Act or any payment to an MCO, PIHP, or PAHP by a State to which the MCO, PIHP, or PAHP is not entitled to under Title XIX of the Act.

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.

Planned: An audit, review, or PI activity that was scheduled as part of the Compliance and FWA Prevention Work Plan based on the organization's risk assessment or other identification method. PI audits are planned based off prior contract year FWA Audits or investigations.

Pre-Adjudication Study: A review of documentation before claims adjudication to determine any billing anomalies, correct coding or other coding initiatives, medical necessity review, or any other review of claims to verify appropriateness. Prepayment auditing detects and prevents billing errors before payment.

Fraud, Waste, and Abuse (FWA) Audit: An initial assessment conducted to determine the validity and scope of a potential issue or concern. This review involves gathering, sampling, and examining relevant information and evidence to decide whether a more comprehensive investigation or audit is warranted. The primary objective is to quickly identify any obvious irregularities or noncompliance and to establish a basis for further action if necessary.

Program Integrity Audit (PI Audit): A Program Integrity Audit involves a systematic examination and evaluation of the policies, procedures, and controls related to the administration of the CCO Contract and Medicaid funds. Its primary objective is to ensure compliance with applicable laws, regulations, and standards, and to identify and mitigate risks of fraud, waste, and abuse. This audit typically includes reviewing Medicaid claims for suspicious patterns or aberrancies to determine if fraud, waste, or abuse has occurred or is likely to occur. It also involves assessing UH's internal controls, verifying the legitimacy of transactions, reviewing financial records, and evaluating the overall efficiency and effectiveness of program operations. The audit aims to establish whether actions of individuals or entities could lead to improper expenditure of Medicaid funds or improper payments under the CCO Contract or Medicaid regulations.

Provider: An individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering provider, or bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a billing provider (BP). The term provider refers to both rendering providers and BP (OAR 410-120-0000).

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

Rendering provider: An individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a provider, or bills, obligates, and receives reimbursement on behalf of a provider of services, also termed a billing provider (BP). The term rendering provider refers to both providers and BP (OAR 410-120-0000).

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.

Subcontractor: Any individual, entity, facility, or organization, including participating providers, that meet the definition of a subcontractor, which has entered a subcontract with the UHA or with any subcontractor for any portion of the work under the CCO Contract (CCO Contract, Exhibit A).

Unplanned: An audit, review, or PI activity initiated outside the initial planned Compliance and FWA Prevention Work Plan, prompted by issues identified through ongoing monitoring, auditing activities, or external sources. Unplanned PI audits scheduled may be in response to results identified during an annual subcontractor compliance performance review, external referrals, emergent issues, identified risks, or concerns that arise outside of the regular audit schedule.

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

Written Policies and Procedures

The Umpqua Health Code of Conduct, FWA Prevention Handbook, and Compliance Program Manual stand as a cornerstone of UHA's FWA Prevention Program. UHA's Board Oversight Compliance Committee, along with the Board of Directors, conducts an annual review of the policies to confirm they meet the current needs of the organization. It establishes the framework and expectations for ethical and compliant behavior among Umpqua Health's staff.

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 to the organization's Code of Conduct. Internal Umpqua Health staff are provided with a copy of the Code of Conduct upon hire and subsequently on an annual basis. External individuals and entities typically receive a copy of the Code of Conduct upon entering a contract with Umpqua Health and on an annual basis thereafter. Umpqua Health maintains a zero-tolerance policy for any conduct that is unlawful, unethical, or inconsistent with its established Code of Conduct.

Internal and external personnel must commit to and comply with the contractual, State, and Federal requirements governing the organization. They should actively participate, exhibit behavior that aligns with the ethical behavior established by the organization, and promptly report any conduct inconsistent with regulations, the Code of Conduct, policies, and procedures.

Internal and external personnel must minimize potential conflicts of interest. In instances where conflicts of interest do arise, individuals and entities must promptly disclose these conflicts to Umpqua Health's Compliance Department. The Compliance Department will collaborate with UHA's Board Oversight Compliance Committee and Board of Directors to implement measures aimed at mitigating such conflicts.

Compliance Leadership and Oversight

Chief Compliance Officer

UHA's Chief Compliance Officer reports directly to the Chief Executive Officer and UHA's Board of Directors and 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 12 of Exhibit B, Part 9 of the CCO Contract. Furthermore, the Chief Compliance Officer is responsible for creating the Annual FWA Prevention Plan, as detailed in Exhibit B, Part 9, Section 13 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: (541) 678-5118
Email: nrickenbach@umpquahealth.com

Program Integrity Operations

UHA has established and is committed to maintaining the investigatory and Program Integrity (PI) Audit capacity necessary to detect potential fraud, waste, and abuse, in compliance with Section 11 of Exhibit B, Part 9, sections 1-20 of the CCO contract and all other State and federal laws. This commitment includes appointing a Chief Compliance Officer and ensuring the specified minimum number and types of Full-Time Employees (FTEs) outlined in the table below. As required, UHA maintains 1 Full-Time Investigator and 1 Full-Time Auditor dedicated to these efforts. The number of FTEs is proportionate to UHA's maximum enrollment limit, which is 64,709 in 2025, as outlined in Section 3.2 of the General Provisions. These FTEs are responsible for conducting PI Audits and investigations of payments made by UHA for all services provided under this contract to Participating Providers, Subcontractors, and other third parties. Such payments include those made through encounter claims, invoices, or capitated payment arrangements. Each FTE Employee will serve exclusively as an investigator or auditor, as specified in the table, to support UHA's PI Audits and investigations. Should UHA delegate any investigation or PI Audit responsibilities to a subcontractor, it will ensure compliance with all requirements and oversight as outlined in the CCO contract.

Maximum Enrollment Limit	Minimum Dedicated FTE Employee(s)	Type of Employee(s)	Chief Compliance Officer
1 to 50,000	1 FTE	Investigator or auditor	1 Chief Compliance Officer
50,001 to 100,000	2 FTE	1 FTE investigator and 1 FTE auditor	
100,001 to 200,000	3 FTE	1 FTE investigator and 2 FTE auditors	
200,001 to 300,000	4 FTE	1 FTE investigator and 3 FTE auditors	
300,001 to 400,000	5 FTE	1 FTE investigator and 4 FTE auditors	
400,001 to 500,000	6 FTE	1 FTE investigator and 5 FTE auditors	
500,001 to 600,000	7 FTE	2 FTE investigator and 5 FTE auditors	

At UHA, we take a meticulous and strategic approach to hiring highly skilled professionals for our Special Investigations Unit (SIU) to ensure the integrity of our compliance and audit processes. Our SIU team consists of Investigators and Compliance Auditors, Claims, both of whom play a vital role in fraud detection, claims analysis, and regulatory compliance.

- Investigators conduct detailed fraud investigations by reviewing claims data, identifying irregular billing patterns, and gathering evidence to determine whether fraudulent activity has occurred. They work closely with internal teams, regulatory agencies, and law enforcement when necessary, compiling investigative reports and making recommendations for corrective actions. These professionals must be able to analyze large amounts of complex data, conduct interviews with providers and stakeholders, and prepare thorough documentation to support their findings.
- Claims Compliance Auditors focus on auditing healthcare claims to ensure accuracy, regulatory adherence, and financial integrity. Their role involves analyzing provider billing practices, identifying potential fraud, waste, and abuse,

and ensuring that claims meet all federal and state regulations. Auditors collaborate with internal compliance and legal teams to assess trends, develop insights, and provide guidance on policy improvements that strengthen program integrity.

The Hiring Process

To ensure we build an exceptionally qualified SIU team, we conduct a nationwide search to identify candidates with strong analytical skills, investigative expertise, and in-depth knowledge of healthcare regulations. Our recruitment team actively sources talent from professional associations, industry networks, and targeted job postings to attract individuals who possess both the technical knowledge and practical experience needed for these roles.

The selection process includes:

- Comprehensive Resume Review – We carefully evaluate candidates' backgrounds, focusing on experience in healthcare fraud investigations, compliance audits, and claims analysis. We prioritize those with proven expertise in identifying fraudulent activity, conducting provider audits, and navigating healthcare regulations.
- Behavioral and Technical Interviews – Candidates meet with senior SIU team members and compliance leaders for in-depth discussions about their experience handling audits, investigating complex fraud cases, and interpreting regulatory requirements. We assess their ability to work under pressure, think critically, and apply their expertise to real-world compliance challenges.

We look for professionals who can navigate the complexities of healthcare fraud and compliance, bringing a detail-oriented, investigative mindset to protect UHA's program integrity.

Special Investigations Unit

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, CPCO
Umpqua Health, LLC.
3031 NE Stephens Street
Roseburg, Oregon 97470
Phone: (541) 464-4984
Email: jsmithreese@umpquahealth.com

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 positions:

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

The Senior Program Integrity Investigator and Program Integrity Investigator are responsible for conducting all Program Integrity Audits and are fully dedicated to these roles within the Special Investigations Unit (SIU). These positions play a critical role in ensuring compliance with regulatory requirements, identifying potential program vulnerabilities, and safeguarding the integrity of healthcare programs by detecting and addressing improper payments, billing anomalies, and other risks that may impact program integrity.

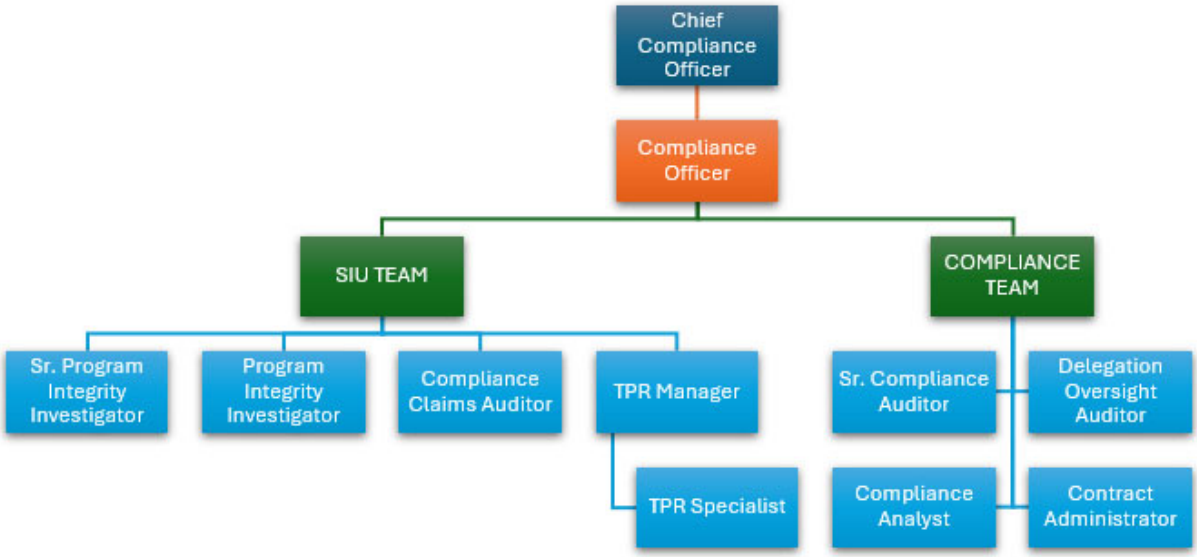
The Compliance Claims Auditor is also exclusively dedicated to their role within the SIU and is responsible for conducting thorough Fraud, Waste, and Abuse (FWA) investigations and claims reviews. This role involves analyzing claims data, identifying

patterns indicative of potential FWA, and collaborating with internal and external stakeholders to ensure compliance with policies, regulations, and industry standards. The findings from FWA investigations and claims reviews directly inform and support Program Integrity Audits, enabling a more comprehensive approach to fraud detection, risk mitigation, and overall program oversight.

Compliance Team

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

- Senior Compliance Auditor
- Delegation Oversight Auditor
- Compliance Analyst
- Contract Administrator



Board Oversight Compliance Committee

Umpqua Health Alliance (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.

The BOCC provides governance oversight of the Compliance Program and the Fraud, Waste, and Abuse (FWA) Prevention Program, including review of program effectiveness, resource allocation, and compliance with contractual, state, and federal requirements.

The BOCC receives reports from the Compliance Officer related to fraud, waste, and abuse prevention, detection, investigation, audits, corrective action plans, and risk mitigation activities.

The structure, composition, quorum requirements, independence standards, authority, and membership of the BOCC are governed by the Compliance Program Manual and the BOCC Charter.

The FWA Prevention Handbook is intended to be read in conjunction with Umpqua Health's Compliance Program Manual.

The Compliance Program Manual establishes governance authority, oversight structure, escalation requirements, and disciplinary standards. This Handbook describes the operational procedures for fraud, waste, and abuse prevention, detection, investigation, response, corrective action implementation, monitoring, and reporting in support of that governance framework.

Training and Education

Umpqua Health considers training and education as a proactive strategy in combatting fraud, waste, and abuse issues. Both internal and external personnel are expected to actively engage with and comprehend the training and education they receive. UHA's education and training activities are designed to inform all levels of its internal and external personnel, including senior management and the Compliance Officer, on the contractual, State, and Federal requirements, which govern the Organization, specifically, the State and Federal FWA laws and whistleblower provisions. This information is first communicated to new employees at onboarding via the Employee Handbook, as well as through provider orientation materials. These training requirements are also outlined in the Organization's Compliance Program Manual. Education and training are conducted through the following means:

1. Web-based training.
2. Live training.

3. Provider forums.
4. Newsletters (employee, members, and providers).
5. Employee Handbook.
6. Provider Handbook.

Additionally, UHA, who annually receives State payment under the agreement of at least $5,000,000, maintains 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 (CO9 – Non-retaliation).

SIU and Compliance Staff

Umpqua Health is committed to investing in and providing education, training, and resources to enhance the knowledge, qualifications, and professional development of its SIU personnel within their respective roles. Certain SIU 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. The Special Investigations Unit includes in its annual budget dollars allocated for training of SIU staff. To support the training and education requirements of SIU personnel, Umpqua Health offers opportunities to attend FWA and compliance conferences, seminars, and webinars, as well as training in coding, auditing, and investigative techniques. Additionally, SIU 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.

Internal Personnel: Employees, Providers and Vendors

New Internal Personnel FWA Training

All new internal personnel are expected to complete online assigned fraud, waste, and abuse training within their first 14 days of employment at Umpqua Health. Exceptions can be made with prior approval from the Human Resources and Compliance Department. Unless an exception is granted, **all** training (including New Hire Compliance Orientation) must be completed no later than 30 days of an individual's first day.

Annual Internal Personnel FWA Training

All internal personnel are expected to complete FWA refresher training annually during each calendar year. Staff are typically given at least 30 days to complete the required trainings; these training courses must be completed by the required due date. Annual training completion is tracked and reported through established compliance monitoring processes Exceptions will be made on a limited basis, as required by law (e.g., medical leave).

Assigned fraud, waste, and abuse specific training courses include the following topics:

i. FWA Prevention Handbook
ii. Umpqua Health's Compliance Policy, False Claims Act and Whistleblower Protection
iii. Oregon False Claims Act
iv. Medicaid Reporting Requirements
v. CO9 – Non-Retaliation

Additional required compliance-related training courses are detailed in the Umpqua Health Compliance Manual.

Internal personnel who fail to complete training by the required due date will be removed from their regular duties/schedule until the training is completed. The employee's direct supervisor, Compliance Officer and Human Resources will be notified and may result in disciplinary actions. Potential actions include:

- Verbal warning
- Written warning
- Suspension
- Termination

Internal Personnel: Provider Network

Annually, Provider Network personnel responsible for credentialing and subcontracting with third parties are trained and educated on material pertaining to provider screening and enrollment requirements (42 CFR § 438.608(b)) and the prohibition of employing, subcontracting, or otherwise maintaining a relationship with sanctioned individuals or entities (42 CFR § 438.214(d)), as required in the CCO Contract, Exhibit B, Part 9, Section 11(b)(8)).

Internal Personnel: Board Members

All new UHA Board Members receive explanatory welcome letters and new board member education packets containing the following FWA documents for review:

i. FWA Prevention Handbook
ii. Compliance Program Manual
iii. Umpqua Health's Code of Conduct
iv. Practical Guidance for Health Care Boards on Compliance Oversight
v. Health and Human Services Office of Inspector General (HHS-OIG) video, "Guidance for Health Care Boards"
vi. Fiduciary Responsibility PowerPoint.
vii. vii. Fraud, Waste, and Abuse PowerPoint

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

UHA Board Members also receive annual FWA and fiduciary responsibility training. When board members are engaged in the review and voting upon material changes to the UHA Compliance Program Manual, FWA Prevention Handbook and the Code of Conduct, annual training on the topics reviewed are not required for that contract year.

External Personnel

Umpqua Health mandates that external personnel, including providers and subcontractors, undergo certain training sessions like 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. External personnel are required to complete the following FWA training on an annual basis:

a. FWA Prevention Handbook
b. Fraud, Waste, and Abuse Training
c. False Claims Act and Whistleblower Protection
d. HIPAA
e. Compliance Training (Code of Conduct and Ethics)

Additional required compliance-related training courses are detailed in the Umpqua Health Compliance Manual.

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

External personnel may elect to utilize their own training or request training from Umpqua Health. If utilizing their own organization's training, external personnel must ensure that it aligns with the materials presented in:

i. CMS Medicare Learning Network resources https://www.cms.gov/training-education/medicare-learning-networkr-mln/resources-training
ii. Umpqua Health Alliance's Coordinated Care Organization contract with the Oregon Health Authority (Exhibit B, Part 9, Section 11).

External personnel may be required to provide evidence of complete training on an annual basis. Individuals and/or organizations that cannot provide evidence will be required to submit a corrective action plan to address the deficiency. Failure to address the lack of training may result in termination of the external personnel contract.

UHA'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 - Screening of Individuals and Entities

Umpqua Health monitors internal and external personnel against applicable State and Federal exclusion/debarment lists monthly and promptly resolves matters in the event an individual or organization is actively sanctioned. Umpqua Health will not initiate or continue a relationship with any individual or entity identified through credentialing or screening as excluded, debarred, or otherwise sanctioned, including those listed on the List of Excluded Individuals/Entities (LEIE) or the System for Award Management (SAM). Umpqua Health will immediately report such individuals or entities to the Federal Department of Health and Human Services, Office of Inspector General (OIG) and the Oregon Department of Human Services (DHS). Reporting requirements will be met by providing information to OHA's Provider Enrollment Unit via Administrative Notice.

The Compliance Program Manual details how Umpqua Health monitors internal and external individuals and/or organizations.

Prohibited Affiliations

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). Disclosure requirements related to ownership and control, prohibited affiliations, and criminal convictions are governed by the Compliance Program Manual. The FWA Prevention Handbook supports these requirements by ensuring that identified disclosures, investigations, and risk responses are operationally managed, tracked, and reported in accordance with contractual and regulatory obligations.

The Compliance Program Manual details how Umpqua Health reviews ownership and control disclosures.

Disclosure of Information Regarding Criminal Convictions

Disclosure requirements related to criminal convictions, ownership or control interests, managing employees, and agents are governed by the Compliance Program Manual.

The FWA Prevention Handbook supports these requirements by ensuring that identified disclosures, investigations, and risk responses are operationally managed, tracked, and reported in accordance with regulatory and contractual obligations.

See the Compliance Program Manual for full disclosure requirements and reporting obligations.

Risk Response & Prevention

Purpose and Authority
In accordance with the Coordinated Care Organization (CCO) Contract with the Oregon Health Authority (OHA) and applicable program integrity requirements, Umpqua Health maintains a Risk Response Process (RRP) to identify, address, mitigate, and remediate deficiencies related to fraud, waste, and abuse (FWA).

The RRP is designed to promote a culture of continuous improvement, with the understanding that deficiencies may occur and must be addressed promptly, effectively, and collaboratively.

Prevention – Risk Assessment and Planning
Annually, or more frequently as needed, Umpqua Health conducts an organization-wide Risk Assessment to identify risks that may affect the organization, including risks related to fraud, waste, and abuse.

The Risk Assessment is used to:

1. identify organizational strengths and weaknesses;
2. guide development of the annual Compliance and FWA Prevention Work Plan; and
3. inform program integrity audits, monitoring activities, investigations, and pre-adjudication studies.

Risk assessments consider internal departments, operational areas (e.g., claims, utilization management, prior authorization, quality review), and external entities including providers, subcontractors, delegated entities, vendors, and members.

The Compliance and FWA Prevention Work Plan is a living document that is reviewed and updated throughout the contract year as new risks or activities are identified.

Identification of Deficiencies

Deficiencies may be identified through multiple mechanisms, including but not limited to:

- internal audits;
- external audits;
- provider audits;
- subcontractor or delegated entity audits;
- program integrity audits;
- investigations;
- monitoring activities;
- hotline reports; and
- Quality Improvement Committee reviews.

Assignment of Risk Responses

When Umpqua Health becomes aware of processes that do not align with regulatory, contractual, or internal requirements, the Compliance Department assigns a risk response to the appropriate party.

Risk responses may be assigned to:

- internal departments or individuals; or
- external personnel, including independent contractors, subcontractors, network providers, or other delegated entities.

Upon assignment of a risk response to external personnel, the Compliance Department provides a copy of the risk response to the Quality Improvement Committee.

Risk Response Tool (RRT)

Assignment of the type and level of risk response is determined using Umpqua Health's Risk Response Tool (RRT), which assesses the likelihood, impact, and severity of the identified risk.

The RRT is based on core elements used by the Federal Sentencing Guidelines. Based on the risk impact score, the Compliance Officer assigns the appropriate response and may adjust the assigned risk response as needed based on the circumstances.

Issues not improved through an initial risk response assignment may warrant escalation to a higher-level risk response.

Types of Risk Responses and Timeframes

Mitigation of identified deficiencies may be addressed using one or more of the following risk responses:

Notice of Opportunity (Notice)

Opportunity Plan (OP)

- Typically up to 180 days to complete

Corrective Action Plan (CAP)

- 90 days

- 60 days
- 30 days
- Less than 3 days, as appropriate, which may include escalation to Human Resources or contract review

Each situation is unique, and the assigned timeframe may vary based on risk severity, impact, and regulatory or contractual requirements.

Development of Risk Response Plans
The assigned party is responsible for developing a risk response plan that:

- addresses the identified deficiencies;
- identifies potential or existing barriers;
- identifies any resources needed to implement corrective actions; and
- includes measurable actions and timelines.

Compliance collaborates with the assigned party to ensure the plan appropriately mitigates the identified issue. However, the prescribed actions and implementation of the risk response remain the responsibility of the assigned party.

Status Updates and Communication
Communication with the Compliance Department is essential throughout the risk response process.

Certain risk responses, including Opportunity Plans and Corrective Action Plans, require routine status updates to Compliance, as indicated by the Risk Response Tool.

Status updates must include:

- date of update;
- progress on each action item;
- barriers encountered;
- supporting documentation, as applicable; and
- requests for extensions, if needed.

Status updates may be provided through meetings or formal written reports. Updates must be provided routinely and in accordance with assigned timelines.

If unexpected barriers arise that may delay completion, the assigned party is expected to notify Compliance as soon as practicable rather than allowing deadlines to lapse.

Extensions
Extensions may be requested through the status update process. The Compliance Officer reviews extension requests and either approves or denies the request. Compliance then notifies the requesting party of the determination.

Completion and Validation
Upon completion of a Corrective Action Plan, Compliance engages in follow-up activities to verify that corrective actions appropriately address the identified deficiency. Verification activities may include:

- auditing; and
- monitoring.

Assigned parties should submit supporting documentation demonstrating completion of corrective actions. Documentation may be submitted during scheduled status updates or at any time upon completion.

Assigned parties are not required to wait for scheduled status updates to notify Compliance that a CAP has been completed.

Escalation and Enforcement
If a risk response does not adequately remediate the issue or is not completed in a timely manner, the Compliance Officer, in consultation with members of the Executive Team and the BOCC, may take additional actions.

Such actions may include:

- disciplinary action;
- reassignment of duties;
- recovery or recoupment of funds;
- contract review, sanctions, or termination; or
- escalation to OHA, as required.

Issues not improved through one risk response assignment may warrant escalation to a higher-level risk response.

External Personnel and OHA Notification
When a subcontractor or delegated entity performing work on behalf of Umpqua Health is found to have deficiencies requiring a Corrective Action Plan:

- Compliance provides a copy of the CAP to OHA via Administrative Notice within required timeframes;
- CAP updates are submitted to OHA on the status and progress of the CAP, as required under the CCO Contract; and
- no more than **14 days** after the stated timeframe for completion, OHA is provided an update indicating whether the CAP was successfully completed or if deficiencies remain.

External personnel are responsible for ensuring status updates are submitted timely to Umpqua Health so that required updates to OHA are provided on time. Repeated failure to submit timely updates or complete corrective actions may result in contractual remedies, including financial penalties.

All notifications, corrective action plans, and updates required to be submitted to OHA will be provided within the timeframes specified in the CCO Contract or as otherwise directed by OHA.

Tracking and Reporting
Compliance maintains:

- an Internal Risk Response Log to track risk responses assigned to internal departments or personnel; and
- a Subcontractor Risk Response Log to track risk responses assigned to subcontractors or delegated entities.

Risk response activity, including assignments, status updates, completions, validations, and escalations, is reported through established governance channels, including the BOCC, to ensure appropriate oversight and timely resolution.

Risk Assessment and Annual Compliance & FWA Prevention Program

The Risk Assessment also informs necessary refinements to Umpqua Health's Compliance Program and FWA Prevention Program.

At the conclusion of the Risk Assessment, Umpqua Health develops an Annual Compliance & FWA Prevention Work Plan that outlines strategies and activities to combat and mitigate identified risks.

The Annual Compliance & FWA Prevention Work Plan is a living document that is reviewed and updated throughout the contract year as new compliance, program integrity, or fraud, waste, and abuse activities are identified.

Compliance governance, Board oversight, and approval authority for the Risk Assessment and the Annual Compliance & FWA Prevention Work Plan are established in the Compliance Program Manual.

The Annual FWA Prevention Plan is submitted to OHA for review and approval no later than January 31 of each contract year. Umpqua Health will not implement the Annual FWA Prevention Plan, or any material changes to the Plan, until OHA approval has been obtained, as required by the CCO Contract.

Fraud, Waste, and Abuse Prevention and Detection Methods

Umpqua Health uses various methods for preventing and detecting member, provider and subcontractor fraud, waste, and abuse in the administration and delivery of services related to the Umpqua Health Alliance CCO contract, including but not limited to oral or written reports by providers, members, and employees. Additionally, Umpqua Health reviews provider contract status, employs claims audits and analysis, claims system edits and flags, data mining and desk or on-site audits of providers' billing practices and service patterns to prevent and detect potential fraud, waste, and abuse.

Pre-Adjudication Studies

The purpose of the Pre-Adjudication Study process is to reduce potential FWA and establish a referral guide on characteristics that would potentially trigger a Program Integrity Audit conducted by UHA's SIU. Additionally, pre-adjudication studies are used to improve billing practices, along with providing education to network providers and subcontractors to prevent future billing abnormalities.

As part of the routine business processes, risk assessment through identified areas of potential concern, and best practices, UHA engages in various forms of pre-adjudication studies to ensure the appropriateness and accuracy of billed services. In general, UHA places efforts in targeting services that pose the greatest risk to the organization, to its members, and stakeholders. Such risks may include financial, medical necessity and quality of care.

Various departments within UHA engage and sanction the deployment of a Pre-Adjudication Study. The departments include Claims Administration, Quality Improvement, Utilization Management and Finance.

Pre-Adjudication Studies analyze claims to determine compliance with:

a. Centers for Medicare and Medicaid (CMS) coding and billing rules,
b. Oregon Health Authority (OHA) Care Coordination Organization (CCO) Contract, c. Federal and State regulations,
d. CMS National Coverage Determinations (NCD)
e. American Medical Association Current Procedure Terminology (CPT®)
f. Healthcare Common Procedure Coding System (HCPCS)
g. International Classification of Diseases (ICD) codes
h. OHA Billing Guidelines
i. Policies and procedures, Provider Handbook and
j. Any other guidelines and contractual requirements.

Pre-adjudication studies take their own unique form in identifying what specific areas to target and what specific materials will be reviewed. Such materials that may be reviewed include, but are not limited to:

a. Claims data;
b. Encounter data;
c. Enrollment records;
d. Medical records;
e. Orders;
f. Prior Authorizations (e.g., days, level of care); and
g. Referrals.

Some examples of Pre-Adjudication Studies include:

a. Eligibility
    i. UHA members and UHA network providers.
b. Accuracy of procedural coding.
    i. Procedure codes (CPT® and HCPCS) and modifiers.
c. Diagnosis.
d. Overutilization of services.
e. Excessive billing by providers.
f. Unit errors.
g. Duplicate charges.
h. Bundling and unbundling of codes.
i. Upcoding.
j. Medically unlikely edits (MUEs).
k. National Correct Coding Initiative (NCCI) Edits.
l. Place of service.
m. Coordination of Benefits
n. Insurance Liability and Recovery (Subrogation)
o. Pricing error.
p. Duplicate item.
q. Medical necessity.
r. Services not covered by Medicaid and/or prioritized lists.

Pre-adjudication studies are completed within timeframes that meet State and Federal timely filing requirements and CCO Contract requirements of reporting accuracy and truthfulness of encounter data.

Each pre-adjudication study will identify and determine what specific information that will need to be present and/or valid to verify compliance. In the event reoccurring patterns or flags, or suspicion of FWA stemming from a pre-adjudication study are identified, UHA may decide to pay the claim in full, deny the claim, or reduce the amount paid to the provider as the identified errors are referred to by UHA's Compliance Department.

Suspicion of FWA Stemming from Pre-Adjudication Study

As previously discussed, each pre-adjudication study is unique in assessing what is appropriate and what needs to be reviewed. However, when patterns or certain behaviors continuously present themselves, further examination of the situation is needed to assess potential FWA.

UHA's evaluation process thoroughly examines all aspects of Medicaid claims to determine eligibility, benefits, potential billing irregularities, proper coding, medical necessity, clinical appropriateness and whether the documentation supports the claim before payment is made. These activities also include monitoring for the recurrence of improper billing practices that were previously identified in prior pre-adjudication studies.

While not inclusive, some reoccurring patterns or flags that may bring suspicion of FWA would take the form of the following but not limited to:

a. Billing anomalies.
b. Lack of medical necessity.
c. Lack of key documentation (e.g., provider signature).
    i. As applicable, Oregon Administrative Rules will be utilized to verify service documentation requirements.
d. Bundling and unbundling of codes.
e. Upcoding.
f. Lack of supporting clinical documentation.
g. Examples of Fraud, Waste, and Abuse characteristics outlined in CO1 – Fraud, Waste, and Abuse, section FWA Referral (2) (CCO Contract, Exhibit B, Part 9, Section 16). h. Any other outlier identified as potential FWA.
i. Any practice that is inconsistent with sound fiscal, business, or medical practices, and which:
    i. Results in unnecessary costs, ii. Results in reimbursement for services that are not medically necessary, or iii. Fails to meet professionally recognized standards for health care.

Another method to identify potentially fraudulent activities is to utilize standard practices for assessing error rates during these studies. As a general benchmark, UHA anticipates an error rate not exceeding 5% during pre-adjudication studies. However, it is important to consider other variables, including:

a. Universe of the services being reviewed.
b. Sample size.
c. Study design.
d. Severity of incident.
e. Definition of an error within the study.
f. Dollar amount involved.

g. Number of members involved.
h. Risk of harm.

Pre-adjudication studies should establish an acceptable error rate before initiating the study, considering the factors outlined above. In the absence of confounding variables, pre-adjudication studies employ a 5% error rate.

Assessing error rates involves various approaches, which can be complex, specifically when trying to conduct a statistically valid study. Due to these complexities, staff performing a pre-adjudication study should stray away from such an approach and utilize one of the following:

a. Standard error rate = Total number of errors divided by the total number of sampled items.
b. Financial error rate = Total dollar amount of errors divided by the total dollar amount of the sample.
c. Improper payment rate = Projected improper payment/Projected paid amount in sample.

If more complex or statistically valid studies are needed, staff should contact the Compliance Department for further assistance before engaging in the pre-adjudication study.

Referral to Compliance Department

If such patterns or behaviors present themselves, staff should refer the matter to the Special Investigations Unit/Compliance Department.

If the result of the pre-adjudication study exceeds the error rate, or other suspicions arise regarding FWA, a referral shall be made to the Compliance Department for further review or for a PI Audit.

Referrals can be made to the Compliance Department via email: compliance@umpquahealth.com and/or hotline.

Information in the referral should include:

a. Provider Name.
b. Provider NPI.
c. Provider DMAP number.
d. Provider Address.
e. Provider TIN.
f. Identified characteristics.
g. Pre-adjudication results, including material used during Pre-Adjudication Study.

h. Any background information on the attempts to educate the provider.
i. Other important and relevant information.

After the Compliance Department receives a referral, the Compliance Department will contact the referrer to gather additional information and understand the full scope of the issue. This will happen within one (1) business day. Compliance will provide instruction and next steps of what may be needed from the referrer. The Compliance Department will then either open a FWA investigation or PI audit.

Information Privacy and Security Protocols

1. Securing and storing audits and supporting documentation will be maintained in accordance with standard operating procedure SOP-CO1-1 - Fraud Waste and Abuse (FWA) and the following Umpqua Health policies:
    a. IT1 - Network Access
    b. H1- General Rules of Uses & Disclosures of Protected Health Information (PHI)
    c. H3- Administrative Requirements for Protected Health Information (PHI)
    d. H12 - Administrative Safeguards Information Systems Activity Review
    e. H13- Technical Safeguards Audit Controls
    f. H15 - Unique User ID and Password Management
    g. H16 - Malware Protection
    h. H19 - Data Backup and Storage
2. Retention and destruction of audits and supporting documentation will be maintained in accordance with CO23 - Record Retention and Destruction.

Verification of Services Audit

Each quarter, Compliance selects a random sample of claims using claims data from the UHA claims payment system. The sample is used to investigate incidents where services were not delivered or where Members paid out of pocket for services, including collecting any associated overpayments. To protect privacy, recipients of confidential services such as mental health, substance use disorder services, or HIV/AIDS are excluded from the sample.

Verification of services are done in accordance with the CCO Contract Exhibit B, Part 9, Section 11(b)(13) and Exhibit J, Section 1(b)(6)); 42 CFRs: §§ 433.116(e) and (f); § 455.20; and § 438.608(a).

Once the random sample of thirty claims is identified, UHA makes three attempts to contact the UHA member to verify they received the services billed to UHA. The first two

contact attempts are made via a survey mailed to the UHA member, for non-confidential services as defined by the State (42 CFR § 433.116(f)). Included with the survey is a pre-paid return envelope to help increase the response rate.

The verification of service survey will specify:

a. The service furnished;
b. The name of the provider furnishing the services;
c. The date on which the service was furnished; and
d. The amount of payment made under the plan for services.

Quarterly tracking logs are maintained identifying the selected sample of members, the service details corresponding to the survey (i.e., name of provider, service provided, date of service, and the amount of payment made under the plan for service), the member's address according to the system and the attempts made to contact the member.

When written responses are received, the completed survey and envelope are scanned into the tracking system to show (1) member responses and (2) date response was received. If a member returns a survey indicating (1) services were not received or (2) member paid for services, the member is contacted by the Compliance Department for further details. Following the communication, if warranted, an investigation ticket will be opened to explore the matter further.

The third attempt to verify the billed services is made via telephone. The UHA member is called at the telephone number on file with UHA Customer Care. If the member is successfully reached and agrees to be surveyed, the results of the phone call are documented on the quarterly tracking log.

If a member supplies a new address and/or phone number, the Compliance Department will provide a copy of the information to UHA's Customer Care Department to ensure the health plan also has the correct address and/or phone number.

When a letter is returned due to the member no longer being at the known address, the envelope is scanned into the tracking system to show the address proved to be invalid. Additionally, the Compliance Department will provide a copy of the information to UHA's Customer Care Department to ensure the health plan is also aware.
Upon request, UHA will provide OHA, its external quality review organizations, or any of its other designees, agents, or subcontractors (or any combination, or all of them) with all collected and reported data available as evidence of having contacted members to confirm receipt of billed services (42 CFR § 438.242).

UHA maintains verification of service records according to UHA's policy CO23 – Record Retention and Destruction.

Data Mining

Data mining is a powerful tool employed by UHA to uncover instances of fraud, waste, and abuse within vast datasets. Through advanced analytical techniques, we sift through large volumes of data to identify patterns, anomalies, and irregularities that may indicate potential misconduct. By leveraging technology, we can efficiently detect unusual patterns or trends that may be indicative of fraudulent behavior or wasteful practices. Data mining not only aids in the early detection of irregularities but also allows us to proactively address potential instances of abuse. This proactive approach enhances our ability to maintain a vigilant stance against fraudulent activities, contributing to a robust system for preventing and combatting fraud, waste, and abuse within our organization.

Activities involve various tasks, including verification of services to confirm that members received the services without incurring any costs (as discussed in the Verification of Services section) and examining elements identified as potentially high risk from the annual risk assessment. Data mining proves invaluable in pinpointing providers or claims that align with the criteria for inclusion in a program integrity audit. These endeavors assist in recognizing providers or claims that meet the specified criteria, making them eligible for consideration in a program integrity audit.

Internal and External Referrals

Referrals of suspected fraud, waste, and abuse (FWA) play a crucial role in initiating FWA and program integrity audits within our organization. When the SIU receives referrals, whether from internal personnel, we treat them as essential leads for potential misconduct. Each referral triggers a thorough investigation process in which the SIU team examines the information provided to determine the validity of the allegations. We analyze the details, gather evidence, and follow a systematic approach to substantiate or dismiss the allegation. The goal is to ensure fairness and objectivity in our assessment. If the investigation reveals credible evidence of fraudulent activities, we proceed to open a FWA or Program Integrity Audit. This process allows us to take appropriate actions, implement corrective measures, and make the necessary referrals to regulatory agencies. Referrals are the first step in uncovering and addressing potential wrongdoing, enabling us to uphold the highest standards of integrity within our organization.

FWA Program Integrity

Program Integrity activities play a vital role in gathering evidence to determine whether instances of fraud, waste or abuse have taken place, are likely to occur, or if the actions of individuals or entities have the potential to lead to Medicaid fund expenditures that do not align with the provisions outlined in the CCO Contract, State or Federal Medicaid regulations. These activities also help to assess where it is necessary to refer a case to UHA's SIU for a program integrity audit.

UHA's FWA Program Integrity Program allows the organization to assess performance objectively against contractual, state, and federal requirements, thus serving as an additional risk assessment tool. The Program is divided into Provider, Subcontractor, Internal, External, FWA Investigation, and Program Integrity (PI) Audits.

UHA is committed to upholding its FWA Prevention Program. The organization continues to enhance its existing program integrity strategies, which include pre-adjudication studies, provider audits, claim and pharmacy reviews, data mining and medical necessity reviews. These efforts are aimed at identifying, preventing, and rectifying potential instances of fraud, waste, and abuse. They also serve to ensure accurate claim payments, prevent improper payments, and uphold integrity of the Medicaid program. Other activities within the health plan, such as quality improvement reviews, credentialing oversight activities and contracting are also considered a part of UHA's Program Integrity Plan.

As part of its program integrity activities, UHA has engaged in contractual agreements with third party organizations who provide forensic services or other specialized skills to support the prepayment review of high dollar claims submitted to the plan. These activities serve as crucial steps in monitoring billing practices, allowing us to identify specific characteristics that may warrant a referral to UHA's SIU for the initiation of a program integrity audit.

Program Integrity (PI) Audits of Providers and Subcontractors enable UHA to validate the accuracy of encounter and claim data against Provider's and Subcontractor's records. PI Audits may also be opened as an investigation in response to questionable billing practices that may deviate from contractual, State, or Federal billing requirements. These audits are used to identify improper payments, including overpayments, with the goal of reducing the payment of Medicaid claims that are not appropriate or valid. PI audits may be opened due to information discovered during investigative activities that warrant an intensified review to substantiate the allegation of fraud, including failure to submit documentation requested for investigation; a provider or subcontractor self-reporting an overpayment; proactively auditing providers identified as high risk during routine monitoring and auditing activities, to ensure services rendered were billed correctly. PI audits are also opened when referrals from external

entities such as the Oregon Health Authority Office of Program Integrity (OPI) or the Medicaid Fraud Control Unit (MFCU) are received.

To ensure accountability, UHA submits a preliminary report for every PI audit initiated to OPI and MFCU, followed by a final PI audit report upon completion of the audit. Any instances of overpayments, whether stemming from FWA or accounting or system errors, made to providers, subcontractors, or other third parties are reported through the referral process outlined below.

UHA also submits quarterly and annual reports to OHA's Contract Administrator. These reports encompass an overview of all PI audits conducted, including those opened, currently in progress, and successfully closed during the specified reporting period. Each quarterly and annual report includes incidents of FWA that align with the characteristics outlined in Section 17 of Exhibit B, Part 9, of the OHA CCO Contract, regardless of whether UHA has any suspicions regarding these incidents. See CA2 – Encounter Data Submission and Validation policy for additional information.

Auditing and Monitoring Process

The auditing and monitoring process is designed to evaluate risks and monitor compliance with the contractual, State, and Federal requirements. In partnership with UHA's parent company, Umpqua Health, evaluating risk and monitoring compliance is primarily done through

- Internal audits.
- External audits.
- Monitoring activities.

UHA uses data mining and data analysis to identify aberrant service patterns, potential areas of overutilization or underutilization, changes in provider behavior, and possible improper billing schemes. The goal of the data analysis process is to identify practices posing the greatest financial risk to Umpqua Health funds, which can in turn result in poor quality of care for members.

Data analysis processes provide a comparative data review on a provider, member, and state basis. With the assistance of resources made available to the SIU, comparative data on how a provider varies from other providers in the same specialty type and geographic area can be composed. Data analysis information is maintained for a period of 10 years. Data analysis can:

- Establish a baseline to enable the SIU to recognize unusual trends, changes in utilization, and/or schemes to inappropriately maximize reimbursement.
- Identifies specific provider and common billing patterns.

- Identifies high volume or high-cost services.
- Identifies provider and patient utilization patterns.
- Identifies provider referral patterns.

Data analysis is a tool for identifying potential errors along with fraud, waste, and abuse through analytical methodologies. The data analysis process uses claim information and other related data to identify potential errors, fraud, waste, and abuse for individual providers, members, or the aggregate.

The UHA SIU team conducts data mining to monitor trends and claims billing abnormalities in UHA claims data.

- 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.
- Excessive referrals to specific providers.
- Providers billing impossible hours in a day.
- Referrals from the Oregon Health Authority Office of Program Integrity and the Medicaid Fraud Control Unit.

FWA Investigations

When a report or identification of suspected fraud, waste or abuse is identified by or communicated to the SIU team, the SIU team analyzes the facts and claims data to determine if the information and circumstances support opening a FWA Investigation.

The FWA Investigation may include, but is not limited to, the following steps:

- Determine if any previous reports of suspected fraud, waste or abuse have been reported or if any previous investigations have been conducted on the provider.
- Review the provider's billing and claim submission pattern to determine if there is any suspicious activity.
- Determine whether the provider in question has ever received educational training regarding the allegation for which the provider is being reviewed.
- Review the OARs, policies and procedures and standard billing practices to determine if the allegation is a violation.
- Obtain and review a small sample of records (typically 5-6 patient records) to determine if the allegation is supported by the medical records.
- Analyze data, findings of record review and determine recommendation for next steps.

After completion of the FWA Investigation, the SIU investigator will review the findings with the Compliance Officer and finalize the next steps in investigation.

If the findings support the allegation of potential FWA, the UHA SIU will open a Program Integrity Audit.

If during the FWA Investigation, it is determined the case was based on a misunderstanding between the complainant and the suspect of the alleged fraud, or there was a claims processing/clerical error, or other rational explanation based on fact, UHA will document the findings of the review and close the case.

Program Integrity (PI) Audits

Program Integrity (PI) Audits are conducted in accordance with the needs identified in the current Risk Assessment and Compliance Program and FWA Prevention Plan or after completion of a FWA Investigation if those findings support the allegation of potential FWA. PI Audits are done in both a proactive and retrospective manner to identify potential situations of FWA. These audits commonly encompass a range of areas, including but not limited to coding, billing, financial, processes, systems, utilization management, medical necessity, clinical appropriateness, non-emergent

transportation (NEMT) service surveys (CO29 – NEMT Quality Assurance Program and Plan), verification of services, etc.

UHA's work plan lists all PI audits planned for the Contract Year, identifying individual(s) or department resources used to conduct reviews, data, or information sources, whether each review is conducted by desk review or on-site, and when each review is scheduled to begin. These audits also include annual audits of UHA's network provider charts to validate the accuracy of encounter claims data.

Investigations, including those related to potential FWA and other related compliance problems, are promptly initiated upon receiving an initial incident report or when identified through self-evaluations and PI Audits. Investigations may include any of the following: interviews or discussions with staff, management, etc.; outsourcing aspects requiring expert review; or documentation review (i.e. healthcare records, financial or claims reports, employee records, etc.).

Certain types of referrals and data mining are opened as PI Audits without completion of a FWA Investigation. Examples include referrals from the Oregon Health Authority Office of Program Integrity and the Medicaid Fraud Control Unit and hotline referrals and data mining that include enough data or facts to support a suspicion of FWA without conducting a FWA Investigation.

A PI Audit may include, but is not limited to, the following steps:

- All PI Audits performed by UHA must be opened within **twenty (20) business days** after UHA receives a written Notice of Potential At-Risk Overpayment from OPI or UHA is notified of a potential Overpayment by an employee, Provider, Subcontractor, Member, or any other internal or external source.
- Refer case to Oregon Health Authority Office of Program Integrity (OPI) within **seven (7) days** of opening case.
- Depending on the allegations, the case may also be referred to the Medicaid Fraud Control Unit (MFCU)
- If the case is referred to MFCU, SIU staff will work collaboratively with MFCU to ensure UHA SIU's investigation does not impede MFCU's investigation.
- Review FWA Investigation report; determine scope of PI audit with Compliance Officer
- Obtain and review copy of UHN Provider Contract
- Obtain and request records for a statistically random sample of medical records (typically 30 patient records)
- Complete coding and documentation review of medical records; determine if a medical necessity review by the Medical Director is warranted.
- Conduct interviews with providers, provider staff and patients, when appropriate
- Conduct on-site visit to provider's office.

Program Integrity Audit Methodology and Scope Development

It is essential to develop a standardized procedure for defining PI Audit scope during the audit's development. A scope defines boundaries and or the extent of the audit, including the subject areas, processes, and review period covered. Desk reviews are most common, but on-site reviews can be included in the initial scope of an audit or investigation, depending on the nature of the allegation. Alternatively, an on-site review may be identified as a necessary next step during the escalation process of the investigation. Defining the scope of the audit or investigation ensures the reviews are conducted systematically and consistently, focusing on areas with the highest risk of non-compliance and fraud, waste, and abuse. The SIU team, the Compliance Officer, and other stakeholders involved in the audit planning and execution must apply the methodology to all PI audits conducted.

Identification of specific providers may use one or more of the following methods: data mining (e.g., risk-based criteria such as volume of claims, types of services provided, and geographic locations); data analytics to identify providers with unusual billing patterns, high error rates, or previous compliance issues; internal audits; external audits; hotline reports; internal and external referrals.

The assigned SIU team member will create a detailed audit plan for provider selection, which will include, but is not limited to, CPT, HCPCS, and revenue codes, diagnoses, dates of service, and data sources. The investigator will clearly document the rationale behind provider selection to maintain transparency and consistency. The plan will outline the information categories to be reviewed during the PI audit, such as encounter/claims data, medical records, and provider contracts, as well as the internal controls and policies governing billing and coding practices required by the health plan. and provide guidelines on accessing and handling sensitive information securely. In addition to ensuring compliance with relevant laws and regulations, such as HIPAA, Anti-Kickback Statute, and False Claims Act. All information for review, including data sources used and the outlined audit schedule, will be documented in the Compliance and FWA Prevention Work Plan (PI Audit).

Each PI Audit, conducted by UHA or subcontractor, shall include all the following, per CCO Contract, Exhibit B, Part 9, Section 15, Para. b, Sub Para. (3), Sub-Sub Para. (a):

1. Validate or verify the following information about the Provider (Provider entities as well as billing Providers and individual rendering Providers as may be applicable):
    A. Provider name(s);
    B. All applicable Provider Medicaid Identification Number(s) and all enrollment file data (e.g., Provider address(es), all practice location(s), and, as applicable for the provider type, the TIN/SSN/EIN, NPI, and taxonomy codes);
    C. Member(s) name(s) and Medicaid ID number, as applicable.

D. Oregon business registration status, legal business name, and, if applicable, assumed business name;
E. Exclusion status of provider(s) (LEIE & SAM) and any person(s) with ownership or control interest (including all managing employees), as these terms are defined by 42 CFR 455.101;
F. Provider license(s) and billing and rendering provider(s), as applicable;
G. Provider certification(s).

2. Collect information about the billing issues identified;
3. Select a PI Audit focus or question, including the billing code(s) selected for review;
4. Review all encounter claims or a statistically valid sample of encounter claims;
5. Review clinical or other financial records;
6. Identify overpayment, total overpayment alleged in a final PI Audit Report or other audit findings;
7. Outcome(s) of a provider appeal of the audit findings; and
8. Overpayment recovery, repayment plan, or other corrective action to prevent future overpayments.

Resolution of Program Integrity Audits

At the completion of a PI Audit, UHA diligently analyzes the findings to determine the appropriate course of action. The results of the PI Audit not only shed light on the specific nature and extent of the misconduct but also guide the implementation of corrective measures. If the investigation substantiates fraudulent activities, appropriate disciplinary actions are taken, ranging from internal sanctions to involving legal authorities. Additionally, the results inform process improvements and policy enhancements to prevent similar incidents in the future. Transparency is prioritized in communicating the outcomes, ensuring that stakeholders are informed about the actions taken and the organization's commitment to upholding integrity and accountability. The insights gained from FWA cases play a pivotal role in refining strategies, fostering a culture of compliance, and maintaining the highest ethical standards within the organization.

Resolution of Program Integrity Audits may include, but are not limited to:

- Recovery of overpayments on claims determined to be paid inappropriately. All overpayments of claims are reported to OPI within 60 days of receiving overpayment.
- Providing education to provider on results of findings.
- Placing provider on pre-payment review to closely monitor future claim submissions.
- Recommending the removal of provider from UHN network.

At the completion of a PI Audit, a final report detailing the findings of the PI Audit is submitted to the Oregon Health Authority Office of Program Integrity and, if appropriate, the Oregon Medicaid Fraud Control Unit.

Each final PI audit report for audits conducted by UHA or subcontractor must contain the following information, per CCO Contract, Exhibit B, Part 9, Section 15, Para. b, Sub Para. (3), Sub-Sub Para. (b):

i. The information gathered about the Provider(s) under Sub-Sub.Para. (a) above of this Sub.Para. (3)
ii. The date range of the Encounter claims audited;
iii. PI Audit focus or question, including the billing code(s) selected for review;
iv. Summary table: Data mining and report on the universe and sample of encounters audited; the clinical or financial records reviewed;
v. Referrals made by Contractor to licensing boards or other state or federal regulatory entities;
vi. Summary of audit criteria applied and the resulting financial and other relevant findings;
vii. Total overpayment alleged in the final PI Audit Report;
viii. The outcome of any Provider appeal(s), as applicable;
ix. Summary of Overpayments recovered, repayment plan, and other Provider corrective action(s) or education or both to prevent future Overpayments by Contractor and the disposition of the PI Audit; and
x. Other relevant audit findings as Contractor deems necessary.

Subcontractor PI Audit Review

UHA is committed to ensuring that all PI Audits performed by its Subcontractors comply with the requirements outlined in CCO Contract Exhibit B, Part 9, Section 15, Paragraph b. To achieve this, UHA shall evaluate all completed final PI Audit reports submitted by its subcontractor for completeness, accuracy, and compliance.

1. **Receipt of final PI Audit report:**
    a. UHA Subcontractor shall submit the completed final PI Audit report within the agreed-upon timeline.
    b. The report must include all required elements as specified under CCO Contract Exhibit B, Part 9, Section 15, Paragraph b.
    c. Upon receipt, UHA shall acknowledge receipt of the report and perform an initial review of the submitted information to confirm the inclusion of all required documentation and data.
    d. If the submission is incomplete, UHA shall notify the subcontractor and request the missing information within a specified timeframe.

2. **Evaluation:**
    a. UHA shall assess the report for the following:
        i. Accuracy of findings and conclusions.
        ii. Completeness of all required sections, as outlined in CCO Contract Exhibit B, Part 9, Section 15, Paragraph b.
        iii. Consistency with UHA's internal standards and expectations.
    b. Any discrepancies or deficiencies identified during this evaluation shall be documented and communicated to the subcontractor for correction or clarification.
3. **Approval or Rejection:**
    a. If the report meets all requirements, UHA shall approve the final PI Audit report and maintain it as part of its records.
    b. If the report is found to be deficient and the subcontractor fails to address identified issues, UHA may escalate the matter per its internal policies or contractual terms.
4. **Documentation and Record Retention:**
    a. UHA shall maintain documentation of the review process, including records of correspondence, findings, and final determinations.
    b. All records shall be retained in compliance with UHA's record retention policy and applicable regulatory requirements.

Examples of Potential FWA

Examples of FWA occurring within UHA's network include, but are not limited to, the following:

i. Providers, other CCOs, or subcontractors intentionally or recklessly report encounters or billing for services that did not occur, supplies, or equipment that are not provided to or used for Medicaid patients.
ii. Providers, other CCOs, or subcontractors that intentionally or recklessly report overstated or up coded levels of service.

iii. Providers, other CCOs, or subcontractors billing for supplies or equipment that are clearly unsuitable for the patient's needs or are so lacking in quality or sufficiency for the purpose as to be virtually worthless;

iv. Providers, other CCOs, or subcontractors claiming costs for non-covered or non-chargeable services, supplies, or equipment disguised as covered items;

v. Providers, other CCOs, or subcontractors materially misrepresenting dates and descriptions of services provided, and the identity of the individual who provided the services or of the recipient of the services;

vi. Providers, other CCOs, or subcontractors duplicate billing of the Medicaid program or of the recipient that appears to be a deliberate attempt to obtain additional reimbursement; and

vii. Arrangements by providers, other CCOs, or subcontractors with employees, independent contractors, suppliers, and other various devices such as commissions and fee splitting that appear to be designed primarily to obtain or conceal illegal payments or additional reimbursement from Medicaid. Providers who consistently demonstrate a pattern of intentionally reporting encounters or services that did not occur. A pattern would be evident in any case where 20% or more of sampled or audited services are not supported by the documentation in the clinical records. This would include any suspected case where it appears that the provider knowingly or intentionally did not deliver the service or goods billed;

1. The 20% threshold would also be used should a provider be suspected of consistently overstating or up coding levels of service;

viii. Any suspected case where the provider, other CCOs, or subcontractors intentionally or recklessly billed UHA more than the usual charge to non-Medicaid recipients or other insurance programs;

ix. Any suspected case where the provider, other CCOs, or subcontractors purposefully altered, falsified, or destroyed clinical record documentation for the purpose of artificially inflating or obscuring his or her compliance rating or collecting Medicaid payments otherwise not due. This includes any deliberate misrepresentation or omission of fact that is material to the determination of benefits payable or services which are covered or should be rendered, including dates of service, charges or reimbursements from other sources, or the identity of the patient or provider;

x. Providers, other CCOs, or subcontractors who intentionally or recklessly make false statements about the credentials of persons rendering care to members or patients;

xi. Providers, other CCOs, or subcontractors who intentionally misrepresent medical information to justify referrals to other networks or out-of-network providers when they are obligated to provide the care themselves;

xii. Providers, other CCOs, or subcontractors who intentionally fail to render medically appropriate covered Services that they are obligated to provide to members or patients under their subcontracts with the Organization and under Oregon Health Plan (OHP) regulations;

xiii. Providers, other CCOs, or subcontractors who knowingly charge UHA members for services that are covered services or intentionally balance-bill a member the difference between the total fee-for-service charge and UHA's payment to the provider, in violation of OHA rules;

xiv. Any suspected case where the provider, other CCOs, or subcontractors intentionally submitted a claim for payment that already has been paid by OHA or UHA, or upon which payment has been made by another source without the amount paid by the other source clearly entered on the claim form, and receipt of payment is known to the provider; and

xv. Any case of theft, embezzlement or misappropriation of Title XIX or Title XXI program money.

xvi. Any practice that is inconsistent with sound fiscal, business, or medical practices, and which: (i) results in unnecessary costs, (ii) results in reimbursement for services that are not medically necessary, or (iii) fails to meet professionally recognized standards for health care.

Examples of FWA occurring within the administration of the OHP program may include, but are not limited to, the following:

i. Evidence of corruption in the enrollment and disenrollment process, including efforts of State employees or contractors to skew the risk of unhealthy patients toward or away from one of the contractors; and
ii. Attempts by any individual, including internal and external personnel, State employees, other CCOs, or elected officials, to solicit kickbacks or bribes. For instance, the offer of a bribe or kickback in connection with placing a member into carve-out services, or for performing any service that the agent or employee is required to provide under the terms of his employment.

Examples of abuse and neglect:

i. Any provider who hits, slaps, kicks, or otherwise physically abuses;
ii. Any provider who sexually abuses;
iii. Any provider, (e.g., residential counselors for developmentally disabled or personal care providers), who deliberately neglects their obligation to provide care or supervision of vulnerable persons who are members (children, the elderly, or developmentally disabled individuals); and

iv. Any Provider who intentionally fails to render medically appropriate care, as defined in the CCO Contract, by the OHP Administrative Rules and the standard of care within the community in which the provider practices.

If the provider fails to render medically appropriate care in compliance with the member or patient's decision to exercise member's right to refuse medically appropriate care, or because the member exercises her/his rights under Oregon's Death with Dignity Act or pursuant to advance directives, such failure to treat the member shall not be considered patient abuse or neglect.

UHA's internal and external personnel are obligated to report all suspicious FWA.

Regulatory Reporting

UHA has an obligation to report (i.e. referral) all suspected cases of fraud, waste, and abuse, including suspected Fraud committed by its employees, Participating Providers, Subcontractors, Members, or any third parties to Oregon's Medicaid Fraud Control Unit ("MFCU"), OHA Office of Program Integrity (OPI), and/or DHS Fraud Investigation Unit promptly but in no event more than seven (7) days after UHA is initially made aware of the suspicious case. This collaboration ensures State agencies are collectively aware of FWA activities conducted by UHA. In addition to the annual and quarterly summary of FWA Referrals and Investigations, UHA must report all suspected cases of Fraud, Waste, and Abuse as follows:

1. **Timely Reporting**:

   UHA, as well as its Subcontractors, shall report suspected cases of Fraud, Waste, and Abuse (including issues related to provider sanctions, suspicions of fraudulent activity, overpayments, and changes in provider or Member circumstances) to OPI and DOJ's MFCU promptly but no later than seven (7) days after becoming aware of the suspicious case. All reporting must adhere to the procedures outlined in Paras. h. and i. of Sec. 18, Ex. B, Part 9.

2. **Use of FWA Referral Form**:

   a. When submitting a referral of suspected Provider FWA or related issues (as defined in Sec. 17 of Ex. B, Part 9), UHA and its Subcontractors must use the FWA Referral Form provided by OHA (available on the CCO Contract Forms Website).
   b.
      The FWA Referral Form must include, at a minimum:
         i. Contractor's name;

ii. Name of Provider or Member;
iii. The suspected issue or allegation;
iv. Information or data has already been reviewed by the Contractor; and
v. Planned next steps for further investigation.

3. **Required Information for Written Referrals**:

   a. All written communications or referrals sent to the Office of Program Integrity (OPI) and the Medicaid Fraud Control Unit (MFCU) by UHA, or its Subcontractors, must include the following

      i. The Contractor's name;
      ii. The Contractor's Medicaid contract number;
      iii. The entity responsible (Contractor or Subcontractor), includes the name, title, and contact information of the individual within the entity who is conducting the investigation, PI Audit, or other review.

   b. UHA will ensure that all Subcontractors adhere to this requirement, including providing the above information in all written referrals or communications sent to OPI and MFCU.
   c. UHA may satisfy this requirement by completing and submitting the FWA Referral Form provided by OHA, which captures all required details.

4. **Anonymous Reporting**:
   a. Individual whistleblowers or any other person(s) who make a report of suspected fraud, waste, abuse, or non-compliance to UHA or its subcontractors shall not be required to use the FWA Referral Form or be required to include identifying information in their anonymous reports. All anonymous FWA reporting shall be accepted by UHA, subcontractors, and participating providers.

The Compliance Officer will maintain a centralized database for tracking FWA reports and ensuring timely submissions to OHA and MFCU. Training sessions will be conducted annually for all staff, subcontractors, and providers to familiarize them with reporting requirements, including the use of the FWA Referral Form and anonymous reporting options. Automated reminders and compliance tools will be utilized to track deadlines and ensure reports are submitted within the seven-day timeframe.

Subject to 42 CFR § 455.23, in the event OHA determines that a credible allegation of fraud has been made against UHA, OHA will have the right to suspend, in whole or in part, payments made to UHA.

In the event OHA determines that a credible allegation of Fraud has been made against UHA's participating provider(s) or subcontractor(s) or both, OHA will also have the right

to direct UHA to suspend, in whole or in part, the payment of fees to any and all such participating provider(s) or subcontractor(s).

Subject to 42 CFR § 455.23(c), suspension of payments or other sums may be temporary. OHA has the right to forgo suspension and continue making payments or refrain from directing UHA to suspend payment of sums to its participating provider(s) or subcontractor(s), if certain good cause exceptions are met as provided for under 42 CFR § 455.23(e).

In the event OHA determines a credible allegation of Fraud has been made against a participating provider or subcontractor, UHA must cooperate with OHA to determine, in accordance with the criteria set forth in 42 CFR § 455.23, whether sums otherwise payable by UHA to such participating provider or subcontractor must be suspended or whether good cause exists not to suspend such payments.

UHA will collaborate with the MFCU and OPI to assist with the investigation, including terminating the network provider agreement.

When referrals are made to the MFCU and OPI, the following information will be supplied:

a. Name and Member ID number.
b. Source of complaint.
c. Type of Provider.
d. Nature of complaint.
e. Approximate dollars involved.
f. Legal and administrative disposition of the case.

UHA is obligated to assist with an investigation conducted by the MFCU, OPI, their respective designees, or any or all of them. Specifically:

a. accounts, and facilities maintained by or on behalf of UHA or by, or on behalf of, any subcontractor/external personnel.
b. Cooperate in good faith and require its subcontractors/external personnel to work with the MFCU and OPI, or their designees.
c. UHA will not notify or otherwise advise its subcontractor/external personnel of an investigation that the MFCU or OPI is actively engaged.
d. Provide copies of reports or other documentation, including requesting information from its subcontractors/external personnel, at no cost to the MFCU and OPI, or their designees.

At the request of OHA, UHA will supply the number of complaints of fraud and abuse that UHA has referred to the OPI and MFCU.

OHA will be notified with an Administrative Notice in the event a network participating in provider's or subcontractor's circumstances change in such a way as to potentially affect the eligibility of that provider or subcontractor to participate in the managed care program, including the termination of the provider agreement with UHA. The Administrative Notice to OHA must occur within 30 days of receiving such information.

Administrative Notice must be provided to OHA's Provider Enrollment Unit within fifteen (15) days of termination, when the termination of a Participating Provider is for-cause, with a statement of the cause of termination (Exhibit B, Part 4, Section 5, Para. k of the CCO Contract).

In the event UHA receives information regarding changes to a member's circumstances that may affect the member's eligibility, such as change in residence or death, UHA will notify OHA on the monthly discrepancy log, but in no event more than 30 days after receipt of information. (42 CFR § 438.608(a)(3))

UHA, providers, and subcontractors shall comply with all patient abuse reporting requirements and fully cooperate with the State for purposes of ORS 124.060 et seq., ORS 419B.010 et seq., ORS 430.735 et seq., ORS 441.630 et seq., and all applicable Oregon Administrative Rules (OARs); this shall include making reports to MFCU and OPI any incident that found to have characteristics outlined in OAR 410-120-1510(2) and/or CCO Contract. UHA shall ensure that all subcontractors comply with this provision.

a. All internal and external personnel shall comply with any patient abuse allegations and will fully cooperate with any State investigations.

Responding to Requests for Additional Information

UHA and its Subcontractors shall maintain detailed records of all Program Integrity (PI) audits and investigations related to suspected Fraud, Waste, Abuse, or overpayments, ensuring sufficient detail to substantiate all actions taken and outcomes reached under the CCO Contract. Additionally, they must allow access to all PI audit and investigation supporting documents, information, systems, and facilities, in accordance with Exhibit B, Part 9, Section 18, and Exhibit D, Section 15 of the CCO Contract.

Furthermore, Subcontractors are required to report any instances of Provider or Member FWA to UHA. To ensure timely reporting to the Oregon Health Authority (OHA) or the appropriate agency, UHA mandates that Subcontractors report such incidents to UHA within a timeframe shorter than UHA's contractual reporting deadlines to OHA. This ensures compliance with reporting obligations and aligns with the CCO Contract.

Non-Delegation of Obligations

UHA retains full responsibility for responding to OPI's requests for additional information or encounter data concerning PI audits or investigations. In accordance with Subparagraph (23), UHA does not delegate this responsibility to its Subcontractors. By maintaining centralized accountability, UHA ensures timely and accurate communication with OPI.

In addition, UHA monitors, audits, and reviews Subcontractor compliance with contractual terms and conditions, including adherence to medical record security and retention policies. UHA documents and maintains records of all Monitoring activities to ensure comprehensive oversight and compliance.

Timely Response to Requests

UHA is committed to providing timely responses to OPI requests for information or Encounter Data. UHA shall respond to OPI within five (5) business days of receiving a request, regardless of whether the requested records are maintained directly by UHA or stored separately by Subcontractors.

As required by Exhibit B, Part 9, Section 20 of the CCO Contract, UHA will provide copies of all PI audit files, encounter data, supporting documentation, and audit criteria within twenty (20) business days of an OPI request. This includes ensuring Subcontractors meet deadlines to supply any necessary documentation to UHA, allowing for timely submission to OPI.

Assessment of Compliance and FWA Documents and Activities

Quarterly and Annual FWA Audit Reports

UHA submits quarterly and annual reports of all PI audits performed, including all PI audits that are opened, in-process, and closed during the reporting period, to OHA by Administrative Notice. Via the CCO Contract Deliverables Portal (CDP), the Quarterly FWA Audit Report, on OHA's provided template (located on the CCO Contract Forms Website), is submitted 30 days following the end of each calendar quarter and the Annual FWA Audit Report, on OHA's provided template, is submitted on January 31st of each Contract Year.

The reports must include all data points listed in the template and information on:

1. All Provider Overpayments identified or recovered (or both) as required under 42 CFR § 438.608;
2. The source of the Provider Overpayment recovery;

3. Any Sanctions or Corrective Actions imposed by UHA on its Subcontractors or Providers, including administered fines; and

With each Quarterly FWA Audit Report submission to OHA, UHA will provide a copy of the final PI audit report for every PI audit marked as closed during the reporting quarter; additionally, any final PI audit reports not previously submitted will be sent. Each final PI audit report will comply with the requirements outlined in the CCO Contract.

OHA will notify UHA of the compliance status of its Annual FWA Audit Report via Administrative Notice within sixty (60) days of the due date or within sixty (60) days of the received date after the due date. If OHA disapproves the Annual FWA Audit Report—including any of UHA's final PI Audit reports for audits identified as "closed" in the Annual FWA Audit Report—due to failure to meet the terms and conditions of the CCO Contract or any applicable laws, UHA shall remedy the identified deficiencies by following the process outlined in Section 5, Exhibit D of the CCO Contract.

Additionally, OHA's OPI may review UHA's Quarterly and Annual FWA Audit Reports and copies of final PI Audit reports and request PI Audit supporting documents, Exhibit B, Part 9, Section 20 of the CCO Contract.

Quarterly and Annual FWA Referrals and Investigations Report

The annual and quarterly FWA Referrals and Investigations Report will be submitted to OHA via Administrative Notice using OHA's provided template (located on the CCO Contract Forms Website) via the CDP. The Annual FWA Referral and Investigations Report will be submitted on January 31st of each Contract Year following the reporting year. The quarterly FWA Referrals and Investigations Report will be submitted 30 days following the end of each calendar quarter. This report will provide a summary of referrals and cases investigated and all UHA's open and closed FWA Audits of suspected and credible cases. The report must include, regardless of Contractor's own suspicions or lack thereof, any incident with any of the characteristics listed in Exhibit B, Part 9, Section 17. UHA will also report Overpayment data, as required under 42 CFR § 438.608, to OHA in a Final PI Audit report due to OHA no later than 30 days following the date:

- Of the total overpayment alleged in the Final PI Audit Report
- The overpayment is recovered

OHA will notify UHA of the compliance status of its Annual Referrals and Investigations Report via Administrative Notice within sixty (60) days of the due date or within sixty (60) days of the received date if after the due date. If OHA disapproves of the Annual Referrals and Investigations Report due to failure to meet the terms and conditions of the CCO Contract or any applicable laws, UHA shall remedy the deficiencies by following the process outlined in Section 5, Exhibit D of the CCO Contract.

Furthermore, OHA's OPI may review UHA's Quarterly and Annual FWA Referrals and Investigations Reports and request investigation supporting documents, as outlined in Exhibit B, Part 9, Section 20 of the CCO Contract.

UHA reviews and updates its Annual FWA Prevention Plan and submits it to OHA via Administrative Notice for review and approval no later than January 31 of each Contract Year. UHA's Annual FWA Prevention Plan must not be implemented or distributed prior to approval by OHA. UHA must utilize the FWA review template provided by OHA and include the completed template with its FWA Prevention Plan submission. These documents shall be provided annually to OHA Contract Administration Unit via Administrative Notice in the manner requested by OHA at the following times:

a. For annual review no later than January 31st.

b. When significant material revisions are made, regardless of whether the changes are made prior or subsequent to OHA's annual approval, or prior to UHA's final adoption of the Plan after OHA's initial approval
c. Whenever OHA requests the Annual FWA Prevention Plan, the Organization will supply the request within 30 days.
d. In response to such submissions, OHA will notify UHA via Administrative Notice within 90 days from the due date, or within 90 days from the received date if after the due date, of the compliance status of it Annual FWA Prevention Plan.

    i. In the event OHA disapproves of the Annual FWA Prevention Plan for failing to meet the terms and conditions of the CCO Contract and any other applicable laws, UHA shall, to remedy the deficiencies, follow the process set forth in Exhibit D, Section 5 of the CCO Contract.

    ii. In addition, if OHA does not approve of UHA's Annual FWA Prevention Plan by July 19 of each contract year due to UHA's non-compliance with the terms and conditions of the CCO Contract, UHA will be in breach of the CCO Contract and OHA shall have the right to pursue all of its rights and remedies under the CCO Contract, including, without, limitation, the imposition of sanctions, including a corrective action plan or civil money penalties, or both.

Annual FWA Assessment Report

UHA submits an annual assessment report of the quality and effectiveness of its FWA Prevention Plan including an introductory narrative of UHA's efforts over the prior contract year and effectiveness of its FWA Prevention Plan to OHA via Administrative Notice, no later than January 31st of each contract year two (2) through four (4). OHA

will advise UHA of its reporting requirements for contract year five (5) at least 120 days prior to the contract termination date.
The Annual FWA Assessment Report must include, with respect to the previous contract year, identifying the following:

i. The number of FWA A by UHA.

ii. The final number of referrals to OPI or MFCU or both.

iii. The number of subcontractor and participating provider PI audits and the number of subcontractor and participating provider reviews that were conducted by UHA and whether each PI audit and review were performed on-site or based on a review of documentation.

iv. Training and education provided for its employees, CCO Chief Compliance Officer, other CCOs, and its providers and subcontractors.

v. All suspected cases of FWA including suspected fraud committed by its employees, providers, subcontracts, members, or any other third parties to OPI or MFCU.

vi. In addition to the annual and quarterly summary of FWA Referrals and Investigations, UHA shall report, regardless of its own suspicions or lack thereof, to the MFCU an incident with any of the characteristics listed in Sec. 17, of this Ex. B, Part 9.

vii. All reporting must be made as set forth in Paras. h. and i. Sec. 18, Ex. B, Part 9 of the CCO contract.

viii. A narrative and other information that advises OHA of the outcomes of all the FWA prevention activities undertaken by UHA and identification of proposed or future process policy, and procedure improvements to address deficiencies; and

ix. Compliance and FWA activities that were performed during the reporting year. The work and activities reported in the Annual Assessment Report must align with UHA's Annual FWA Prevention Plan. The work and activities must be clearly described and be specific to the reporting year. UHA will provide the information below for each program's integrity activity and work conducted in the prior contract year:

1. A review of the provider PI audit activity UHA performed based on UHA's Annual FWA Prevention Plan.

2. A description of the methodology used to identify high-risk providers or services.

3. Compliance reviews of subcontractors, participating providers, and any other third parties, including a description of the data analytics relied upon.

4. Any applicable requests for technical assistance from OHA, DOJ's, MFCU, or CMS on improving the compliance activities performed by UHA; and

5. Include a sample of service verification letters mailed to members and report on the number of service verification letters sent, member response rates to mailings, frequency of mailings, and description of how members are selected to receive service verification surveys, including all dates on which such letters were mailed, the results of the efforts, and other methodologies used to ensure the accuracy of data.

x. A narrative and other information that advises OHA of:

1. The outcomes of all the Fraud, Waste, and Abuse prevention activities undertaken by UHA, and
2. Proposed or future process, policies, and procedure improvements to address deficiencies identified. UHA must identify where work or activities identified in its Annual FWA Prevention Plan were not implemented or were implemented differently than initially described by UHA in its Annual FWA Prevention Plan and explain how and why the FWA prevention activities changed.

xi. A copy of each final report resulting from UHA's compliance reviews of its subcontractors and participating providers completed during the prior contract year as well as any corrective action plans resulting from such compliance reviews.

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.

Overpayments and Recoveries

UHA must report to OHA any overpayment to Providers, Subcontractors, or other third parties under the CCO Contract—or any related contract, agreement, or MOU—regardless of how it was discovered (whether self-reported or identified by UHA) or its cause (fraud, waste, abuse, accounting, or system error). UHA must notify OHA of any overpayment within 60 days of identification, per 42 CFR § 401.305.

UHA is required to conduct PI audits to identify overpayments made to Providers, Subcontractors, and third parties, and to report both identified and recovered overpayments to OHA—whether the overpayment is discovered through self-reporting by a Provider, Subcontractor, or third party, or through UHA's own identification processes. This obligation applies regardless of whether the cause is fraud, waste, abuse, or an accounting or system error, as detailed in the CCO Contract, Exhibit B, Part 9.

- If an overpayment is identified through self-reporting to UHA by a Provider, Subcontractor, or third party, the entity that received the overpayment is responsible for both reporting and returning the overpayment to UHA. This must be done in accordance with 42 CFR § 401.305(b)(1), which requires that the overpayment be reported and returned by the later of:
  - 60 days after the date the overpayment was identified, or
  - The due date of any corresponding cost report, if applicable.

- All such reports made by the Provider, Subcontractor, or other third party must include a written statement identifying the reason(s) for the return of the Excess Payment. Providers will be made aware of this process through UHA's education and training activities.

- If Overpayment was identified by UHA at any time in the course of a PI audit or investigation and the Overpayment is due to suspected or potential (or both) Fraud, Waste or Abuse, such Overpayment will be reported to OHA promptly, but in no event more than seven days after identifying such Overpayment.

- If Overpayment was identified by UHA as a result of a PI Audit or investigation:

  - The Total Overpayment alleged in the Final PI Audit Report must be reported by UHA to OHA promptly but in no event more than 30 days, as required under 42 CFR § 438.608. UHA shall report such Overpayment to OHA in a final PI Audit Report, in accordance with the CCO Contract, Exhibit B, Part 9.
  - The recovered Overpayment must be reported by UHA to OHA promptly, but in no event more than 30 days after the date that UHA recovers the

Overpayment as required under 42 CFR § 438.608. UHA shall report such Overpayment to OHA in a final PI Audit Report in accordance with the CCO Contract, Exhibit B, Part 9.

In addition to the reporting required under Exhibit B, Part 9 of the CCO Contract, UHA will ensure that all overpayments are accurately reported in its semi-annual and annual Financial Reports, as required in Exhibit L. UHA's Exhibit L Report must include all overpayments—whether identified or recovered—regardless of whether they resulted from:

(i) self-reporting by UHA to OHA, any overpayments received, or any overpayments identified because of self-reporting to UHA by Providers, Subcontractors, or third parties;
(ii) a routine or planned PI Audit;
(iii) a PI Audit or another type of review;
(iv) an accounting or system error.

Treatment of Provider Overpayment Recoveries Due to FWA

For investigations resulting in fraud referral to OHA and the Department of Justice MFCU (or both), UHA must obtain written consent from OHA prior to the initiation of any recovery due to fraud or potential fraud.

UHA shall report all identified and recovered overpayments on the quarterly and annual Exhibit L report (i.e., L6), regardless of whether the overpayments were the results of self-reporting or result of a routine or planned PI audit or other review. UHA shall adjust, void, or replace, as appropriate, each encounter claim to reflect the proper claim adjudication.

UHA shall maintain records of the actions of UHA, providers, subcontractors, and third parties related to overpayment recovery, and make those records available for OHA review upon request.

UHA shall adjust, void, or replace, as appropriate, each encounter claim to reflect the proper claim adjudication once UHA has recovered overpayment within 30 days of identifying the overpayment in accordance with OAR 410-141-3570 and CCO Contract Exhibit B, Part 8, Sections 11-13.

In the event UHA investigates or conducts PI audits of its providers, subcontractors, or any other third-party and overpayments made to such parties are identified as the result of fraud, waste, or abuse, UHA may collect and retain such overpayments as set forth in Exhibit B, Part 9, Section 15, paragraph b. of the CCO Contract.

Examples of overpayment types that may be collected and retained include, but are not limited to, the following:

1. Payments for non-covered services.
2. Payments above the allowable amount for an identified covered service.
3. Errors and non-reimbursable expenditures on cost reports.
4. Duplicate payments.
5. Receipt of Medicaid payment when another payer had the primary responsibility for payment and is not included in an automated TPL retroactive recovery process.
6. Recoveries due to waste or abuse as found in audits, investigations, or reviews; or
7. Credit balance recoveries.

UHA does not have the right, under the CCO Contract, to retain any provider overpayment that is otherwise recovered and retained as a result of (i) claims brought under the False Claims, (ii) fraud cases, or (iii) through government investigations, such as amounts recovered by the OHA, the OPI, or the DOJ's MFCU.

Financial Recoveries from Audits of Network Participating Providers and Subcontractors

If OHA conducts a PI audit of a UHA provider or subcontractor or the provider's or subcontractor's encounter claims data, that results in:

a. A finding overpayment, OHA shall calculate the final overpayment amount for the audited claims using the applicable fee-for-service fee schedule and recover the overpayment from UHA. UHA shall have the right to then pursue recovery from the provider and subcontractors at its discretion.

b. An administrative or other non-financial finding, UHA agrees to use the information included in OHA's final audit report to rectify any identified billing issues with its providers and pursue financial recoveries for improperly billed claims if applicable.

UHA's Contract Administrator and Chief Compliance Officer will be notified via Administrative Notice by OHA of any PI audit findings of Overpayment and its decision relating to means of and timeframe for recovery. Recovery of OHA identified overpayments of UHA's network participating providers or subcontractors, UHA will follow the process outlined in OAR 410-120-1396. UHA may appeal an Overpayment determination by submitting a written request to OHA's OPI within 30 calendar days

from the postmark date of the final audit report. Appeals will be conducted by OPI in the manner described in OAR 410-120-1396.
UHA may be liable for up to triple the total Overpayment amount of the final PI audit report if OHA discovers that a UHA participating provider has continued the same or similar improper billing practices as established, or upheld if appealed, in a previously published final audit report by OPI or has been warned in writing by DHS, OHA, OPI, or DOJ about the same or similar improper billing practices, in accordance with OAR 410-120-1396.

If UHA or its subcontractor conducts PI Audits of UHA's Providers or Providers' encounter data that results in a finding of overpayment, UHA is permitted to keep any funds recovered.

Recoveries that are made by UHA must be reported to OHA on the quarterly and annual Exhibit L financial report, as well as the Quarterly and Annual FWA Reports and the Annual FWA Assessment Report.

Stark and Anti-Kickback

UHA fully complies with the Physician Self-Referral Law (aka "Stark Law") and Anti-Kickback Statue (AKS). Accordingly, any financial relationship with a physician, or a physician's family member must fit within an applicable exception under the Stark Law and a safe harbor under the Anti-Kickback Statue.

Stark Law (42 USC § 1395nn) The Stark Law prohibits a physician who has a financial relationship with an entity that provides designated health services (DHS) from:

a. Making a referral to that entity for DHS that are reimbursed by Medicare and Medicaid.

b. The entity where there is a financial relationship may not seek reimbursement from Medicare or Medicaid or bill to any individual, third-party payor, or other entity for the DHS in the event it was performed.

Any arrangement that is implicated in the Stark Law must fall within an exception under the law.

To review the penalties for violations of the Stark Law, including failure to report information, see 42 USC § 1395nn(g)

Anti-Kickback Statue (AKS) (42 USC § 1320a-7b(b)) The AKS prohibits all internal personnel from offering, paying, soliciting, or receiving something of value to induce or reward referrals for services reimbursed by Federal health care programs. Any arrangement must fall within an applicable safe harbor.

To review the penalties for violations of the AKS, see 42 USC § 1320a-7b(b).

Oversight

All internal personnel are trained in **Stark Law** and **AKS** at time of hire and annually thereafter. Any internal personnel that engage in any conduct that is incongruent with the Stark Law and AKS will be subject to disciplinary actions, up to and including termination.

External Reporting

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:

a. An employee licensure problem.
b. A network provider credentialing issue.
c. Contract deficiencies associated with Umpqua Health Alliance's Coordinated Care Organization Contract with the Oregon Health Authority (OHA).
d. Contract deficiencies associated with services delegated by Atrio to Umpqua Health.
e. Claims overpayments.
f. Stark, Anti-Kickback, or False Claims Act matters.

In the event a potential issue is identified, the Compliance Department will coordinate with other departments and/or legal counsel to gather additional information and if necessary, conduct a larger investigation and properly report the mater externally, including law enforcement, when the Compliance Officer reports any substantial external reporting situations to the Board Oversight Compliance Committee and Umpqua Health's Board of Directors.

External Fraud, Waste, and Abuse (FWA) Reporting Requirements

Reporting of Sanctioned and Excluded Individuals or Entities

UHA must immediately report to the OIG any providers identified during the credentialing process, who are included in 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. 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.

Referrals to Medicaid Fraud Control Unit (MFCU) and/or OHA Office of Program Integrity (OPI)

All suspected cases of Fraud, Waste, and Abuse reports that contain characteristics like the examples listed in the Program Integrity section of this manual will be referred to MFCU and OPI, prior to validation and no more than seven (7) days after UHA is initially made aware of the suspicious case, as stipulated in the UHA Coordinated Care Organization (CCO) Contract Exhibit B, Part 9, Section 18(d). All reporting must be made according to foregoing contract paragraphs h. and i. of Section 18, Exhibit B, Part 9.

Referrals to DHS Fraud Investigation Unit

Suspicion of member fraud will be reported to DHS Fraud Investigation Unit in accordance with State and CCO Contract requirements.

Overpayments

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)).

Network providers will notify UHA in writing of discoveries of overpayments, including the reason for the overpayment, and will return overpayments to UHA within 60 calendar days after the date on which the overpayment was identified. Providers are made aware of this process through UHA's education and training activities.

If overpayment is identified by UHA because of an PI audit or investigation, the overpayment will be reported to OHA promptly, but in no event more than seven (7) days after identifying the overpayment.

UHA provides an annual report to the State as evidence of recoveries in payments.

UHA retains such records of overpayments in accordance with policy CO23 – Record Retention and Destruction. This includes maintaining documentation for payment of recoveries of overpayments to the State in situations where UHA is not permitted to retain some or all the recoveries of overpayments.

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.

Reporting Suspected FWA

UHA's internal and external personnel are obligated to report all suspicious FWA activities to the Compliance Department, including any concerns about the actions of OHA personnel. Matters are to be reported when they are received, and internal personnel shall not attempt to substantiate an allegation prior to making a report.

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 www.umpquahealth.ethicspoint.com (can report anonymously).

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 of reporting 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).

In the event it is determined that internal personnel were aware of an issue, but did not report that matter, the internal personnel will be subject to discipline, up to and including termination.

Hotline

Umpqua Health has contracted with a third-party vendor to establish a hotline for individuals to report compliance and FWA matters. The hotline is available to all individuals, both inside and outside the organization, including members and providers within the community. The hotline is a critical element of the FWA Prevention Program as it provides a way for individuals to report FWA concerns anonymously through a third party. 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, employees, and subcontractors.

Umpqua Health's 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 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 is 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

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.

Hotline reports will be reviewed by the Compliance Department and documented in the Compliance Log. The Compliance Department will determine whether an investigation is warranted, and if necessary, begin the investigation process. If contact information is provided by the reporter, the Compliance Department will reach out to the reporter for more information if necessary.

UHA uses a Case Manager Database to receive allegations, track, triage and refer to (i) Medicaid Fraud Control Unit (MFCU)/ OHA Office of Program Integrity (OPI) for fraud or abuse 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.

UHA is prohibited from referring allegations to a subcontractor who is also a party to the allegation.

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.

The Compliance Department provides 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.

Cooperating with Investigations

Umpqua Health is dedicated to ensuring that internal and external personnel understand the importance of investigations. Umpqua Health requires full cooperation from internal and external personnel in any investigation conducted or participated in by Umpqua Health.

Throughout one's employment or contractual relationship with Umpqua Health, individuals or entities may be requested to participate in investigations conducted or participated in by Umpqua Health. It is the expectation that all internal and external personnel fully cooperate with any of Umpqua Health's investigations. Failure to cooperate, intentional interference with an investigation, dishonesty, or any actions detrimental to an investigation may result in disciplinary measures, up to and including termination of employment or contractual relationship. In the event where personnel do not cooperate or disrupt an investigation, the Compliance Officer will coordinate with the Human Resources Department and the Chief Executive Officer for potential sanctions.

Umpqua Health internal personnel, external personnel and its subcontractors must cooperate in good faith with MFCU, OPI and their designees, in any investigation or PI audit relating to FWA as follows:

a. Provide copies of reports or other documentation requested, as required under Exhibit B, Part 9, Section 18, Para. (f), Subparagraph (1) of the CCO Contract, without cost to MFCU, OPI, or their designees.
b. Permit MFCU, OPI, or their respective designees, or any combination or all of them, to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities maintained by or on behalf of UHA as such parties may determine is necessary to investigate any incident of FWA.
c. Cooperate in good faith with the MFCU, OPI, as well as their respective designees, or any or all of them, during any investigation of FWA; and
d. In the event that UHA reports suspected FWA by UHA's Subcontractors, Providers, Members, or other third parties, or learns of an MFCU, OPI investigation, or any other FWA investigation undertaken by any other governmental entity, UHA is strictly prohibited from notifying, or otherwise communicating with, such parties about such report(s) or investigation(s).

Procedures for Responding to Requests for Additional Information from OPI

To ensure compliance with federal regulations and contractual obligations, UHA has established a comprehensive process for responding to written requests from the Office of Program Integrity (OPI) for additional information or Encounter Data

UHA is solely responsible for responding to OPI requests and does not delegate this responsibility to Subcontractors. However, Subcontractors must report any suspected Fraud, Waste, or Abuse involving Providers or Members to UHA promptly, allowing

sufficient time for UHA to meet its reporting obligations. Subcontractor reporting timelines are shorter than UHA's deadlines to ensure timely submission to OPI or other agencies. UHA must respond to OPI requests within five (5) business days and provide all PI Audit files, Encounter Data, and supporting documentation, including methodologies and criteria used during the audit, within twenty (20) business days, as specified in Exhibit B, Part 9, Section 20.

To support this process, UHA ensures that Subcontractors provide access to all PI Audit records, supporting documents, and systems for review and allows UHA to conduct monitoring, audits, and reviews to verify compliance. All monitoring activities are documented and maintained by UHA as part of its compliance program. Prior to submission, UHA's compliance team reviews all responses to OPI for accuracy and completeness. All communications with OPI, including supporting documentation, are transmitted securely to comply with data protection standards. UHA's Compliance Officer oversees these procedures and conducts periodic reviews to ensure adherence to FWA policies and the terms of the CCO Contract.

Enforcement & Discipline

A key component of the FWA Prevention Program is ensuring FWA infractions are met with appropriate corrective action, and if necessary disciplinary actions, which are equitable for all internal personnel throughout the organization.

When FWA concerns involving both internal and external personnel are identified, the SIU 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, as outlined in the Compliance Prevention Manual.

All internal personnel, regardless of position and rank, are responsible for complying with contractual, State, and Federal requirements. Additionally, internal personnel are expected to comply with the policies, procedures and Code of Conduct and Ethics that govern the organization.

Behavior, conduct, or activities that are incongruent with the contractual, State, and Federal requirements, along with internal policies and procedures, are deemed compliance infractions.

The identification of compliance infractions can come from numerous sources including, but not limited to:

a. Investigations.
b. Internal audits.
c. External audits.
d. Monitoring activities.

In the event a compliance infraction is identified, the Compliance Department will coordinate with the internal personnel manager and the Human Resources Department to identify the specific requirements that were violated.

Once it becomes identified that a compliance infraction has occurred, the Compliance Department will recommend that some form of disciplinary action occur. All recommendations from the Compliance Department must be approved by the Compliance Officer.
The Compliance Department will inform, and if necessary, consult the Human Resources Department, of the severity level of the infraction. Human Resources and the internal personnel manager will review the recommendations from the Compliance Department to determine the appropriateness, as there may be other factors to consider that the Compliance Department was not aware of. If the Human Resources Department and/or management disagree with the recommendations, the parties will engage their department executive for assistance.

For Privacy and/or Security violations, the Compliance and Human Resources Department has created the following guidelines for sanctioning internal personnel. These are "suggested guidelines" as other factors may be considered depending on past conduct, personnel past performance, cooperation, etc.:

Level 1: Accidental use or disclosure of protected health information.

- Suggested discipline: Written warning.

Level 2: Accessing own record; multiple Level 1 instances in a relatively short period.

- Suggested discipline: Final warning.

Level 3: Access or disclosure due to curiosity, personal gain, malicious intent, and/or significant negligence; multiple Level 2 offenses.

- Suggested discipline: Termination.

In the event the department manager and Human Resources Department should disagree with the Compliance Department's recommended disciplinary action, the issue

should be elevated to the Department Executive for direction. The department manager and Human Resources Department are to review the suggested alternate form of disciplinary action with the department executive. If after review, the department executive determines that an alternative form of disciplinary action is warranted, the department executive will engage the Chief Compliance Officer to ensure alignment. If the department executive and the Chief Compliance Officer do not reach alignment, the parties will engage the Chief Executive Officer for a final decision. Any alternate form of disciplinary action must be approved by the Chief Compliance Officer prior to any action taken by the Human Resources Department.

Upon completion of the disciplinary process, the Human Resources Department will confirm to the Compliance Department whether disciplinary action occurred.

All disciplinary actions, including alternative disciplinary actions, must be documented with the Compliance Department case file, along with the rationale and policy violated.

Contact Information for Reporting Fraud, Waste, and Abuse

Provider Fraud

UHA must report any suspected or confirmed Fraud, Waste, or Abuse (FWA) by a Participating Provider, Subcontractor, or its own employees to the MFCU and OPI, as required under Exhibit B, Part 9, Section 18, Paragraphs (h) and (i) of the CCO Contract. Such reports may be submitted through any of the methods specified for MFCU and OP:

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

OHA Office of Program Integrity (OPI)
500 Summer St. NE, E36
Salem, OR 97301
Secure email: OPI.Referrals@oha.oregon.gov
Hotline: 1-888-FRAUD01 (888-372-8301)
https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx

Member Fraud

Where to Report a Case of Fraud or Abuse by a Member
UHA, if made aware of suspected Fraud or Abuse by a Member (e.g., a Provider reporting Member FWA) must promptly report the incident to the DHS FIU. Such reporting may be made by mail, phone, or facsimile transmission using the following contact information:

ODHS Fraud Investigation Unit
PO Box 14150
Salem, Oregon 97309
Hotline: 1-888-FRAUD01 (888-372-8301)
Fax: 503-373-1525 ATTN: Hotline
https://www.oregon.gov/odhs/financial-recovery/Pages/fraud.aspx