CORPORATE POLICY & PROCEDURE

	Policy Name: Fraud, Waste, and Abuse
Department: Compliance	Policy Number: CO1
Version: 11	Creation Date: 5/1/2013
Revised Date: 1/29/14, 1/1/17, 7/18/17, 1/12/18, 1/10/19, 5/24/19, 6/20/19, 7/24/19, 1/13/20	Review Date: 1/12/16

Line of Business: ☒ All

☐ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Newton Creek	☐ Physician eHealth Services
☐ UHA Community Activities	☐ Umpqua Health Network
☐ Professional Coding and Billing Services	☐ ACE Network

Signature:

Approved By: Michael A. von Arx, COO & Chief Compliance Officer Date: 1/30/2020

Approved By: Board Oversight Compliance Committee Date: 1/9/2020

POLICY STATEMENT

Umpqua Health Alliance (UHA), and its parent company Umpqua Health (collectively "the Organization"), are committed to establishing a Compliance Program and Fraud, Waste, and Abuse (FWA) Plan that combats FWA, and any conduct which goes against the contractual, State and Federal requirements that the Organization is bound by.

PURPOSE

The purpose of this policy is to outline the structure of the Organization's FWA Prevention Plan, along with its process for referring FWA activities, as required by the Oregon Health Authority's (OHA) Coordinated Care Organization (CCO) Contract.

RESPONSIBILITY

Internal personnel, external personnel.

DEFINITIONS

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Organization or OHA or in 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 the Organization or OHA (OAR 410-120-0000(1)).

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

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable Federal or State law (OAR 410-120-0000(96)).

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

Relationship: A director, officer, partner, subcontractor, a person with beneficial ownership of 5% or more of the Organization, network provider or person with an 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.

Subcontractor: Any participating provider or any other individual, entity, facility, or organization that has entered into a subcontract relationship with the Organization or with any subcontractor for any portion of the work under the CCO Contract.

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

PROCEDURES

Structure of FWA Prevention Plan

1. As a condition of participation in the Medicaid managed care program, the Organization's FWA Prevention Plan, along with its Compliance Program, is designed to meet contractual, State, and Federal requirements, including:
    a. CCO Contract, Exhibit B, Part 9, Sections 11-18.
    b. Oregon Administrative Rules (OAR) 410-120-1510.
    c. 42 CFR § 433.116.
    d. 42 CFR § 438.214.
    e. 42 CFR § 438.600 through 42 CFR § 438.610.
    f. 42 CFR § 438.808.
    g. 42 CFR § 455.20.
    h. 42 CFR § 455.104 through 42 CFR § 455.106.
    i. 42 CFR § 1002.3
2. The Compliance and Ethics Program along with the FWA Prevention Plan, is designed to incorporate the seven effective elements of a Compliance Program, including:
    a. The designation of a Chief Compliance Officer who reports directly to the organization's Chief Executive Officer as well as the organization's Board of Directors. The Chief Compliance Officer is dedicated to and responsible for implementation and oversight of the Compliance Program and FWA Prevention Plan.
        i. The organization has established a Board Oversight Compliance Committee which meets at least quarterly to ensure the Compliance

Program and FWA Prevention Plan are operating appropriately, effectively, and have the necessary resources.

b. The creation of a Code of Conduct and Ethics document that aligns with policies and procedures of the regulatory requirements that the organization is bound to enforce.
    i. All internal and external personnel are required to comply with UHA's and its parent company, Umpqua Health's Code of Conduct and Ethics program.
        1. Specifically, internal and external personnel are expected to commit to and comply with the contractual, State, and Federal requirements that govern the organization.
        2. Be active participants and engage in behavior that aligns with the ethical behavior established by the organization.
        3. Report any conduct that is incongruent with regulations, the Code of Conduct and Ethic, policies, and procedures.

c. The Organization's education and training activities are designed to inform all levels of its internal and external personnel, including senior management and the Chief Compliance Officer, on the contractual, State, and Federal requirements, which govern the Organization, specifically, over the State and Federal FWA laws and whistleblower provisions (CO6 - Compliance Training). This information is initially 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 and FWA Prevention Plan Handbook. Education and trainings are conducted through the following means:
    i. Web-based trainings.
    ii. Live trainings.
    iii. Provider forums.
    iv. Newsletters (employee, members, and providers).
    v. Employee Handbook.
    vi. Provider Handbook.

Additionally, UHA who annually receives State payment under the agreement of at least $5,000,000, will maintain written policies for all employees of Umpqua Health, and any contractor or agent, that provides detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be

protected as whistleblowers (CO6 - Compliance Training, CO9 – Non-retaliation, and CO13 - Internal Reporting).

d. Risk Assessments are completed annually (1) to identify company strength and weaknesses, and (2) to guide development of the annual Compliance Program. Together the assessment and the plan work to monitor potential FWA problem areas such as claims, prior authorization, verification of services (CO28 - Verification of Services), utilization management, and quality review. The Risk Assessment, in conjunction with the annual Compliance Work Plan helps identify the specific auditing and monitoring processes that will occur in a given year.
e. 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:
    i. Internal audits.
    ii. External audits.
    iii. Monitoring activities.
    iv. FWA audits.
        1. Planned in accordance with the needs identified in the current Risk Assessment and Compliance Program and FWA Prevention Plan. These audits often review processes, systems, utilization management, non-emergent transportation (NEMT) service surveys (CO29 – NEMT Quality Assurance Program and Plan), verification of services (CO28 - Verification of Services), etc.
        2. These audits also include annual audits of UHA's network provider charts to validate the accuracy of encounter claims data.
    v. Investigations
        1. Promptly started upon receipt of the initial incident report or as are identified in the course of self-evaluation.
        2. 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.).
    vi. Subcontractor audits.
    vii. Monitoring tactics.
        1. To ensure its internal and external personnel are in good standing with licensing boards (if applicable) and are not excluded from participating in Federal and State healthcare programs. Should personnel be identified as sanctioned, the Oregon Department of

Human Services (DHS) and the U.S. Department of Health and Human Services Office of Inspector General (OIG) will be promptly notified and the relationship with the Organization will cease. Screening is done through the credentialing and recredentialing process for network providers (CR3 – Screening of Providers), along with monthly monitoring of the following databases:

a. Health and Human Services Office of Inspector General's (HHS-OIG) List of Excluded Individuals (LEIE).
b. Excluded Parties List System (EPLS), also known as System for Award Management (SAM).
c. State licensing boards (for licensed internal personnel).

f. UHA's contractual arrangements call for its external personnel to prohibit employment relationships with any individuals sanctioned and excluded from participation in Federal and State healthcare programs.
    i. UHA must immediately report to the OIG any providers identified during the credentialing process, who are included on the LEIE or on the EPLS. Reporting requirements can be met by providing such information to OHA's Provider Services via Administrative Notice.
    ii. Participating providers and credentialing staff are educated on this requirement through the distribution of this policy.
g. No relationship shall be established or maintained with an individual or entity that has been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
h. The Organization intends to establish effective lines of communication for its internal personnel, external personnel, and its members to report compliance and FWA matters. This is done by having an open-door policy within the organization, as well as operating a Compliance Hotline (CO15 – Hotline) which allows for anonymous reporting. UHA's Compliance Hotline can be accessed by:
    i. Phone: (844) 348-4702
    ii. Online: www.umpquahealth.ethicspoint.com

Additionally, UHA's Member Grievance and Appeal Program allows for members to report concerns anonymously.

iii. To further support and encourage reporting, UHA and its parent company, Umpqua Health, has a strict zero-tolerance policy on retaliation (CO9 – Non-Retaliation).
iv. Reported issues are responded to promptly through the Compliance Department's Case Manager Database. When reports are lodged, either through the website or the hotline, the database immediately issues a notification email to the Compliance Department. Upon receipt of the notification, the report is reviewed and investigated.

i. The Organization has established enforcement and discipline processes for its internal and external personnel who engage in behavior or conduct that does not align with the Code of Conduct and Ethics document (CO19 - Disciplinary Process for Compliance Infractions).
    i. These processes and standards are consistently applied to all individuals regardless of position, rank, or contractual status within the organization.
j. The Organization promptly responds to and prevents further occurrences of non-compliance by using its corrective action plan (CAP) process (CO18 – Corrective Action Plan Process). This process allows internal and external personnel to resolve matters that are out of compliance with regulatory requirements, or have violated the Compliance Program and FWA Prevention Plan.
    i. The CAP process utilizes administrative means (e.g. policy revision, procedural adjustments, training) along with disciplinary standards to correct any misconduct.

<u>FWA Referral</u>

1. The Organization closely collaborates with State and Federal agencies when there is suspicion of FWA by its internal personnel, external personnel, or members, including any allegations specified in the CCO Contract and with 42 CFR § 455.23. This is done by submitting FWA referrals within seven (7) days from suspicion arising:
    a. Provider FWA Referrals
        i. Medicaid Fraud Control Unit (MFCU)
        Oregon Department of Justice
        100 SW Market Street
        Portland, OR 97201
        Phone: 971-673-1880
        Fax: 971-673-1890
        ii. OHA Program Integrity Audit Unit (PIAU)
        3406 Cherry Ave NE
        Salem, OR 97303-4924

Fax: 503-378-2577
Hotline: 1-888-FRAUD01 (888-372-8301)

b. Member FWA Referrals
   i. DHS/OHA Fraud Investigation Unit
   P.O. Box 14150
   Salem, Oregon 97309-5027
   Hotline: 1-888-FRAUD01 (888-372-8301)
   Fax: (503) 373-1525 ATTN: Hotline

2. In the event a case is referred to UHA or Umpqua Health, an investigation will be opened to review the matter and determine whether the allegation is credible for suspicion of FWA. However, reports which contain characteristics similar to the examples listed below, will be referred to MFCU prior to verification and PIAU as stipulated in the CCO Contract, Exhibit B, Part 9, Section 17(e).
   a. 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.

b. Examples of FWA occurring within the administration of 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 a carved out program, or for performing any service that the agent or employee is required to provide under the terms of his employment.

c. 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.
      1. 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.

3. The Organization'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.
4. UHA's members are educated through the Member Handbook on how to report suspicious FWA activities.

5. In the event the Organization deems an allegation credible for fraud and the MFCU or PIAU has a pending case against a provider, the Organization shall suspend payment to the provider, unless directed not to by the MFCU or PIAU. Additionally, the Organization will collaborate with the MFCU and PIAU to assist with the investigation, including terminating the network provider agreement.
    a. Subject to 42 CFR § 455.23, in the event OHA determines that a credible allegation of fraud has been made against the Organization, OHA will have the right to suspend, in whole or in part, payments made to the Organization.
6. In the event a referral is made to the MFCU and PIAU, 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.
7. The Organization is obligated to assist with an investigation conducted by the MFCU, PIAU, their respective designees, or any or all of them. Specifically:
    a. Allow inspection, evaluation, or audit of books, records, documents, files, accounts, and facilities maintained by or on behalf of UHA or by, or on behalf of, any subcontractor/external personnel.
    b. Cooperate and require its subcontractors/external personnel to work with the MFCU and PIAU, or their designees.
    c. UHA will not notify or otherwise advise its subcontractor/external personnel of an investigation that the MFCU or PIAU is actively engaged.
    d. Provide copies of reports or other documentation, including requesting the information from its subcontractors/external personnel, at no cost to the MFCU and PIAU, or their designees.
8. At the request of OHA, UHA will supply the number of complaints of fraud and abuse that UHA has referred to the PIAU and MFCU.
9. OHA will be notified with Administrative Notice within 30 days in the event a network provider's circumstances change in such a way as to potentially affect the eligibility of that provider to participate in the managed care program, including the termination of the provider agreement with UHA.
10. UHA will quickly notify OHA in the event it receives information about developments in an member's circumstances that may affect the member's eligibility, such as change in residence or death (42 CFR § 438.608(a)(3)).

11. 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 PIAU 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.

FWA Overpayments

1. With respect to overpayments by UHA to providers, UHA will document identification methods as well as timeframes and will retain such records of overpayments in accordance with policy CO23 – Record Retention and Destruction. This will include maintaining documentation for payment of recoveries of overpayments to the State in situations where UHA is not permitted to retain some or all of the recoveries of overpayments (42 CFR § 438.608(d)).
    a. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.
2. In the event an overpayment pertaining to capitation payments or other payments is identified as being fraudulent, a report will be made to OHA within 60 calendar days (42 CFR 438.608(d)).
    a. In writing, network providers, subcontractors, and third-parties will notify UHA 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 will be made aware of this process through UHA's education and training activities.
    b. UHA will provide an annual report to the State as evidence of recoveries of payments.
    c. UHA will retain such records of overpayments in accordance with policy CO23 – Record Retention and Destruction. This will include maintaining documentation for payment of recoveries of overpayments to the State in situations where UHA is not permitted to retain some or all of the recoveries of overpayments
3. If identification of overpayment was the result of self-reporting to UHA by a provider, subcontractor, or third-party, or identified by UHA and regardless of whether the overpayment was the result of fraud, waste, or abuse or an accounting error it must be reported, as required under 42 CFR § 401.305, within 60 days of the identification of the overpayment to OHA.

4. If overpayment was identified by UHA as a result of an audit or investigation, the overpayment must be reported to OHA promptly, but in no event more than seven (7) days after identifying the overpayment.
5. Treatment of Provider Overpayment Recoveries Due to FWA
    a. 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.
    b. 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 audit or other review. UHA shall adjust, void or replace, as appropriate, each encounter claim to reflect the proper claim adjudication.
    c. 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.
    d. 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.
    e. In the event UHA investigates or audits 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 14 of the CCO Contract.
        i. 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 in excess of the allowable amount for an identified covered service;
            3. Errors and non-reimbursable expenditures in 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.
    f. UHA does not have the right, under the CCO Contract, to retain any provider overpayments that are 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 PIAU, or the MFCU.

Financial Recoveries from Audits of Network Providers

1. If OHA audits a UHA provider or encounter claims data, that results in:
    a. A financial finding of 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 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 provider and pursue financial recoveries for improperly billed claims if applicable.
2. If UHA or its subcontractor conducts an audit of UHA's provider or encounter claims data that results in a financial finding, UHA is permitted to keep the recovered amount outside of any applicable federally matched funds which must be returned to OHA.
3. Recoveries that are retained by UHA must be reported on the quarterly and annual Exhibit L financial report, as well as the Quarterly and Annual FWA Reports and the Annual FWA Assessment Report.

Assessment of Compliance and FWA Documents and Activities

1. Quarterly and Annual FWA Audit Reports.
    a. UHA shall provide quarterly and annual reports of all audits performed to OHA's Contract Administrator, via Administrative Notice, the Quarterly FWA Report, on OHA's provided template, 30 days following the end of each quarter and the Annual FWA Audit Report, on OHA's provided template no later than January 30th of each contract year.
        i. The reports will include information on:
            1. A summary of recovered provider overpayments;
            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
            4. Any other information requested in OHA's reporting template.
    b. The Annual FWA Referrals and Investigations Report will be provided to OHA via Administrative Notice using the FWA Report Template. Submissions will be done promptly by January 1st of each contract year, but no later than January 31st.
        i. This report will provide a summary of referrals and cases investigated.

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2. UHA shall review and update its Compliance Program and FWA Prevention Plan Handbook as well as its policies and procedures annually. These documents shall be provided 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 unless the Organization attests to no changes since the last submission using OHA's "Fraud, Waste, and Abuse Annual Attestation Template";
    b. When significant material revisions are made or prior to initial adoption of a new plan or handbook; or
    c. Whenever OHA requests these documents for review.
    d. In response to such submissions, OHA will notify UHA via Administrative Notice to UHA's Contract Administrator within 30 days of the compliance status of the policy.
3. Annual FWA Assessment Report.
    a. UHA shall submit an annual assessment report of the quality and effectiveness of its FWA Prevention Plan including an introductory narrative of the foregoing efforts and effectiveness of its FWA Prevention Plan to OHA via Administrative Notice, no later than January 31st of each contract years 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.
    b. The Annual FWA Assessment Report must include, with respect to the previous contract year, identifying all of the following:
        i. The number of preliminary investigations;
        ii. The final number of referrals to PIAU or MFCU or both;
        iii. The number of subcontractor and provider audits and the number of subcontractor and provider reviews that were conducted by UHA and whether they were performed on-site or based on a review of documentation;
        iv. Training and education provided for its employees, CCO Compliance Officer, other CCOs, and if applicable, 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 PIAU or MFCU;
        vi. UHA must report regardless of its own suspicions or lack thereof, to the MFCU an incident with any of the characteristic listed in Exhibit B, Part 9, Section 16 of the CCO Contract. All reporting must be conducted as stated in this policy under section FWA Referral;

vii. 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

viii. Compliance and FWA activities that were performed during the reporting year. Such report must include:

1. A review of the provider 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, providers, and any other third parties, including a description of the data analytics relied upon;
4. Any applicable requests for technical assistance from OHA 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.

4. 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.