CareOregon®

Fraud, Waste and Abuse Handbook

CareOregon Dental

Columbia Pacific CCO
Creating Health Together

Jackson Care Connect
Your Community Health Plan

OPENING STATEMENT

To our Employees, Board Members and Contractors:

At CareOregon, its subsidiaries and affiliates (including, but not limited to; CareOregon Advantage, CareOregon Dental, Columbia Pacific CCO, Jackson Care Connect and Housecall Providers), collectively, “CareOregon”, we are committed to our corporate mission of providing better health, better care, and better cost to the people and communities we serve. We strive towards this mission under the guidance of our vision and corporate values.

To that end, we have implemented FWA Prevention Policies and Procedures (FWA Handbook). The FWA Handbook is the framework and foundation by which we articulate our commitment to comply with State and Federal laws, regulations, and our internal policies and procedures.

No matter the line of business we work with, compliance is everyone’s responsibility. We want you to familiarize yourself with this document and use all the tools at your disposal to maintain our high standard of compliance and ethical behavior. We thank you for your continued support in our ongoingcommitment to serve our members in the best and most ethical manner.

Contents

WHO DOES THIS APPLY TO?

This FWA Handbook applies to all CareOregon employees, officers, and Board and Committee members who participate in any aspect of the organization's business. In addition, this FWA Handbook applies to our first tier, downstream or related (FDR) entities, Subcontractors, Delegates, vendors, and Participating Providers, when required and in accordance with the applicable Attachments.

WHAT IS EXPECTED OF ME?

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

ADOPTION & DISSEMINATION

Adoption

The FWA Handbook, Code of Conduct, and supporting policies and procedures will be reviewed and updated on at least an annual basis. If required by a particular regulatory agency, these documents will be reviewed and/or approved by that regulatory agency prior to formal approval and adoption of the documents by the Compliance Committee. If substantive changes are required more frequently than annually, these documents will be subject to the same review, approval, and adoption process that is required during the annual review.

Dissemination

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

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

Board of Directors:

- At time of Appointment: The Compliance Officer will disseminate the FWA Handbook and Code of Conduct to new members of the Board of Directors upon their appointment and prior to attending their first meeting.

- Annually: The Compliance Officer will disseminate the FWA Handbook and Code of Conduct to members of the Board of Directors annually thereafter, and when there are substantive updates.

Definitions

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

Administrative Notice: this is an Oregon Health Authority (OHA) and Coordinated Care Organization (CCO) specific term that means a notice from Contractor (the CCO) to OHA, or from OHA to Contractor (the CCO), for purposes of administering the Contract, which meets the requirements set forth in Section 23, Paragraph b. of Exhibit D of the contracts between OHA and CareOregon Community Solutions (CCO Contract(s).

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

Business Owner (BO): a CareOregon staff member who's typically the individual with the most overall ownership and/or responsibility of a particular business function.

CareOregon: Includes, but not limited to; CareOregon Corporate; the affiliated CCOs Jackson Care Connect and Columbia Pacific CCO; CareOregon Advantage; CareOregon Dental; CareOregon as a service provider for both Integrated Delivery System (IDS) and Tribal contracts; and HouseCall Providers.

Compliance: refers to CareOregon's internal Corporate Compliance Department and/or staff members.

Contract Administrator(s): the individual or department that's responsible for the relationship with an external entity such as a FDR, Subcontractor, Delegate, Participating Provider or other third party.

Contractor: means an Applicant selected through RFA OHA-4690-19-0 and is the party that entered into the CCO Contract with OHA.

Corrective Action Plan (CAP): A Compliance Department request for an internal operational business unit, a Regulator-initiated request for CareOregon or a CareOregon-initiated request of FDRs, Subcontractors, Delegates, and Participating Providers to develop and implement a time specific plan for the correction of identified areas of noncompliance or FWA.

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

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

Downstream Entity: is any party that enters into a written arrangement, acceptable to the Centers for Medicare and Medicaid Services (CMS), with persons or entities involved with the Medicare Advantage (MA) benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization (MAO) or applicant or a Part D plan sponsor or applicant and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. (See, 42 C.F.R. §423.501).

Employee: For purposes of applying this FWA Handbook, the Code of Conduct and its supporting policies and procedures, an employee includes the following: all full time and part time employees, all temporary employees, volunteers, all casual employees, and all interns (paid or unpaid).

External Quality Review (EQR): EQR means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness and access to the health care services that CareOregon furnishes to its Members, and other EQR-related activities as set forth in 42 CFR 438.358**.**

External Quality Review Organization (EQRO): means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354 and performs external quality review, other EQR-related activities as set forth in 42 CFR 438.358 or both.

First Tier, Downstream, Related Entity (FDR): See individual definitions for each term**.**

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

Fraud: intentional deception or misrepresentation that any individual including employees, Subcontractors, Participating Providers, Members, and/or other third parties knows, or should know, to be false, or does not believe to be true, and makes knowing the deception could result in some unauthorized benefit to themselves or some other employee, Subcontractor, Participating Provider, Member, and/or other third parties.

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

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

Participating Provider: means a physician, facility, or other provider of health- related services that holds a contract with one or more of CareOregon's Coordinated Care Organizations in Oregon.

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

SharePoint/MS Teams: a mechanism CareOregon's Compliance Department utilizes to implement its Compliance Program. It's' a Microsoft Office product that maintains CAP forms, Monitoring results, Audit results, disseminated regulatory information, etc.

Statute of Limitations: The time limit for bringing an action before a court or administrative agency.

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

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

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

MFCU: Medicaid Fraud Control Unit

OPI: Office of Program Integrity

DHS/OHA FI: DHS/OHA Fraud Investigation

OHA: Oregon Health Authority

SAM: System for Award Management

OIG: Office of Inspector General (OIG) List of Excluded Individuals

What is the FWA Handbook

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

This FWA Handbook is applicable to all CareOregon Employees and all CareOregon subsidiaries or affiliated entities including but not limited to Health Plan of CareOregon, Inc., Columbia Pacific CCO, LLC, Jackson County CCO, LLC, Housecall Providers Services, LLC, Housecall Providers, PC, and Care Access, LLC. The Code of Conduct, in combination with this document, and the supporting policies and procedures listed in the tables below make up the FWA Handbook.in accordance with requirements set forth in 42 CFR §438.600-438.610, §433.116, §438.214, §438.808, §455.20, §455.104 – 455.106, §1002, and OAR 141-120-1510. This FWA Handbook enables CareOregon to detect, prevent and correct potential FWA activities that have been engaged in by our employees, Subcontractors, Participating Providers, Members, and/or other third parties.

How to Report FWA Concerns

CareOregon takes these matters very seriously, and we comply with all applicable laws, including the State and Federal False Claims Act. If you identify suspicious activity, or if you want to report a case of fraud, waste, abuse, or any other compliance concern you can do so using any of the following options below.

Anyone, including Employees, member of the Board of Directors, subcontractor, business associate, FDR, participating providers or members can report issues or concerns of potential compliance, privacy, or FWA:

1. Call the EthicsPoint Corporate Compliance Hotline Call Center at 1-888-331-6524 or file a report on the EthicsPoint Corporate Compliance Website (EthicsPoint - CareOregon, Inc.) and include information on the origin of the incident, member information, provider information, claim information, date and time of the incident, and other applicable information.
    a. EthicsPoint allows submitters to select the option to remain anonymous.
2. The VP of Audit & Compliance can be reached at 503-416-4700.
3. Email to: CareOregonComplianceDepartment@careoregon.org .

Concerns may also be reported through CareOregon's Member Grievance and Appeals process which also allows for anonymous reporting. CareOregon emphasizes the obligation to report compliance and FWA issues by bolstering a safe environment for reporters and whistleblowers to report without fear of retaliation as CareOregon strictly prohibits anyone from retaliating against any person who reports matters in good faith.

For other reporting options refer to the *Reporting Suspected Compliance, FWA or HIPAA Concerns P&P*

Attachment 1 CCO Program Integrity Review

CAREOREGON FWA PREVENTION HANDBOOK (CCO Contract, Exhibit B, Part 9, Section 11(b))		
#	**Contents**	**Corresponding Policy/Procedure**
1	Designation and identification of a Chief Compliance Officer who reports directly to the CEO and the Board of Directors and who is responsible for: a) Developing and implementing the written policies and procedures set forth in Paragraph b, Section 11 of Exhibit B, Part 9; and Creating the Annual FWA Prevention Plan (as such Plan is described in Section 12 of Exhibit B, Part 9).	• CCO Ethics and Compliance Program
2	Establishment and identification of the members of a Regulatory Compliance Committee, which shall include the Chief Compliance Officer, senior level management employees, and members of the Board of Directors. The Regulatory Compliance Committee will be responsible for overseeing the FWA prevention program and compliance with the terms and conditions of the CCO Contract.	• CCO Ethics and Compliance Program • Compliance Committee Charter
3	Establishment of a division, department, or team of employees that is dedicated to, and is responsible for, implementing the Annual FWA Prevention Plan; and which includes at least one professional employee who reports directly to the Chief Compliance Officer. Examples of a professional employee are an investigator, attorney, paralegal, professional coder, or auditor. CareOregon must demonstrate continuous work towards increasing the qualifications of its employees. Investigators must meet mandatory core and specialized training program requirements for such employees. The team must employ, or have available to it, individuals who are knowledgeable about the provision of medical assistance under Title XIX of the Act and about the operations of health care providers. The team may employ or have available through consultant agreements or other contractual arrangements, individuals who have forensic or other specialized skills that support the investigation of cases.	• Org Chart Audit and Compliance Department • CCO Ethics and Compliance Program
4	A statement or narrative in the FWA Prevention Handbook that articulates the CareOregon's commitment to complying with the terms and conditions in sections 1-18 of Exhibit B, Part 9 of the Contract and all other applicable State and Federal laws.	• CCO Ethics and Compliance Plan • Pg. 2 of this document

5	Written standards of conduct for all CareOregon employees that evidence compliance with CareOregon's commitment to FWA prevention and enforcement in accordance with the terms and conditions of the CCO contract and all other applicable State and federal laws.	• Code of Conduct
6	A description of CareOregon's disciplinary guidelines used to enforce compliance standards and how those guidelines are publicized.	• CCO Ethics and Compliance Program
7	A system to provide and require annual attendance at training and education regarding CareOregon's FWA policies and procedures. a. Such training and education must include, without limitation, the right, pursuant to Section 1902(a)(68) of the Social Security Act, to be protected as a whistleblower for reporting any FWA. b. CareOregon's system for training and education must provide all information necessary for its employees, Subcontractors and Participating Providers to fully comply with the FWA requirements of the Contract. c. All such training and education must be specific and applicable to FWA in the Medicaid program. All training must include Medicaid-specific referral and reporting information and training regarding CareOregon's Medicaid FWA policies and procedures, including any time parameters required for compliance with Ex B, Part 9 of the Contract. d. All such training and education must be provided to, and attended by, CareOregon's Compliance Officer, senior management, and all CareOregon's other employees.	• Compliance and FWA Training • CCO Ethics and Compliance Program •
8	In addition to the training and education required under #7 above, a system to provide annual education and training to CareOregon's employees who are responsible for credentialing Providers and Subcontracting with third parties. Such annual education and training must include material relating to, as set forth in 42 CFR §438.608(b) and 438.214(d): (i) the credentialing and enrollment of Providers and Subcontractors and (ii) the prohibition of employing, Subcontracting, or otherwise being affiliated with (or any combination or all of the foregoing) with sanctioned individuals.	• Compliance and FWA Training Policy

9	Systems designed to maintain effective lines of communication between CareOregon's Compliance Officer and CareOregon's employees and subcontractors.	• CCO Ethics and Compliance Program • Reporting Suspected Compliance, FWA or HIPAA Concerns •
10	Systems to respond promptly to allegations of improper or illegal activities and enforcement of appropriate disciplinary actions against employees or Subcontractors who have violated FWA policies and procedures and any other applicable State and federal laws.	• SIU Investigations and Reporting Policy • CCO Ethics and Compliance Program
11	Procedures for reporting FWA to the appropriate agencies in accordance with Exhibit B, Part 9, Section 17 of the CCO contract.	• SIU Investigations and Reporting Policy
11a	In addition to its reporting requirements with respect to Providers under Exhibit. B, Part 9, CareOregon must immediately report to the Federal Department of Health and Human Services Office of the Inspector General, any Providers, identified during the credentialing process, who are include on the List of Excluded Individuals or on the Excluded Parties List System also known as System for Award Management. Reporting requirements can be met by providing such information to OHA's Provider Enrollment Unit via Administrative Notice.	• OIG/SAM Exclusion Screening • Credentialing - Adverse Actions •
11 b	Using the template provided by OHA (located on the CCO Contract Forms Website), and in accordance with CareOregon's FWA Prevention Handbook and Annual FWA Prevention Plan, CareOregon must submit to OHA quarterly and annual reports of all PI Audits performed. a) The Annual and Quarterly FWA Audit Reports must include all data points listed in the template, information on any Provider Overpayments that were recovered, the source of the Provider Overpayment recovery, and any Sanctions or Corrective Actions imposed by CareOregon on its Subcontractors or Providers. b) For both the Quarterly and Annual FWA Audit Reports, CareOregon must report all PI Audits opened, in-process, and closed during the reporting period.	• SIU Investigations and Reporting of suspected FWA

	c) CareOregon must also provide to OHA with each Quarterly FWA Audit Report a copy of the final PI Audit report for each PI Audit identified in the FWA Audit Report as closed during the reporting quarter. d) The Annual FWA Audit Report is due January 31 of each Contract Year and must be provided to OHA via Administrative Notice. e) The Quarterly FWA Audit Report is due thirty (30) days following the end of each calendar quarter and must be provided to OHA via Administrative Notice.	
11 c	Using the template provided by OHA (located on the CCO Contract Forms Website), CareOregon must submit to OHA, via Administrative Notice, an annual and quarterly summary report of FWA Referrals and cases investigated. a) The report must include, regardless of CareOregon's own suspicions or lack thereof, any incident with any of the characteristics listed in section 16 of Exhibit B, Part 9. b) The report must include all CareOregon's open and closed preliminary investigations of suspected and credible cases. c) The annual FWA Referrals and Investigations Report is due January 31 of each Contract Year following the reporting year and must be provided to OHA via Administrative Notice. d) The quarterly FWA Referrals and Investigations Report is due thirty (30) days following the end of each calendar quarter and must be provided to OHA via Administrative Notice.	• SIU Investigations and Reporting of suspected FWA
11 d	In addition to the annual and quarterly summary of FWA Referrals and Investigations, CareOregon must report all suspected cases of FWA, including suspected Fraud committed by its employees, Participating Providers, Subcontractors, Members, or any other third parties to OPI and DOJ's Medicaid Fraud Control Unit (MFCU). a) Reporting must be made promptly but in no event more than seven (7) days after CareOregon is initially made aware of the suspicious case.	• SIU Investigations and Reporting of suspected FWA

	b) All reporting must be made as set forth in paragraphs h. and i. of section 17, Exhibit B, Part 9.	
11 e	In addition to the annual and quarterly summary of FWA Referrals and Investigations, CareOregon must report, regardless of its own suspicions or lack thereof, to the MFCU an incident with any of the characteristics listed in section 16 of Exhibit B, Part 9. All reporting must be made as set forth in paragraphs h. and i., of section 17 of Exhibit B, Part 9.	• SIU Investigations and Reporting of suspected FWA
11 f	CareOregon must cooperate in good faith with MFCU and OPI, or their designees, in any investigation or PI Audit relating to FWA as follows: a) CareOregon must provide copies of reports or other documentation requested by MFCU, OPI, or their respective designees, or any or all of them. All reports and documents required to be provided under subparagraph (1) of paragraph f, section 17, Exhibit B, Part 9 must be provided without cost to MFCU, OPI, or their designees; b) CareOregon must 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 CareOregon as such parties may determine is necessary to investigate any incident of FWA; c) CareOregon must 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 CareOregon reports suspected FWA by CareOregon's Subcontractors, Providers, Members, or other third parties, or learns of an MFCU, or OPI investigation, or any other FWA investigation undertaken by any other governmental entity, CareOregon is strictly prohibited from notifying, or otherwise communicating with, such parties about such report(s) or investigation(s).	• SIU Investigations and Reporting of suspected FWA

11 g	Subject to 42 C.F.R. §455.23, in the event OHA determines that a credible allegation of Fraud has been made against CareOregon, OHA will have the right to suspend, in whole or in part, payments made to CareOregon. a) In the event OHA determines that a credible allegation of Fraud has been made against CareOregon's Subcontractors, OHA will also have the right to direct CareOregon to suspend, in whole or in part, the payment of fees to any and all such Subcontractors. b) Subject to 42 C.F.R. §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 CareOregon to suspend payment of sums to its Subcontractors, if certain good cause exceptions are met as provided for under 42 C.F.R. §455.23(e). c) In the event OHA determines a credible allegation of Fraud has been made against a Subcontractor, CareOregon must cooperate with OHA to determine, in accordance with the criteria set forth in 42 C.F.R. §455.23, whether sums otherwise payable by CareOregon to such Subcontractor, must be suspended or whether good cause exists not to suspend such payments.	• SIU Investigations and Reporting of suspected FWA
11 h	CareOregon, if made aware of any suspected FWA by a Participating Provider, Subcontractor, or its own employees, must report the incident to MFCU and OPI as required under Ex, B, Part 9. Such reporting may be made by mail, phone, or facsimile transmission using the following contact information: Medicaid Fraud Control Unit (MFCU) Oregon Department of Justice 100 SW Market Street Portland, OR 97201 Phone: 971-673-1880 Fax: 971-673-1890 OHA Office of Program Integrity (OPI) 3406 Cherry Ave. NE Salem, OR 97303-4924 Fax: 503-378-2577 Hotline: 1-888-FRAUD01 (888-372-8301)	• SIU Investigations and Reporting of suspected FWA • JCC Member handbook • CPCCO Member handbook

	https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx CareOregon must include the above contact information for MFCU and OPI in its FWA Prevention Handbook and its Member Handbook. **Where to Report a Case of Fraud or Abuse by a Member** CareOregon, 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 Fraud Investigation Unit (FIU). Such reporting may be made by mail, phone, facsimile transmission, or online using the following contact information: **DHS/OHA Fraud Investigation** PO Box 14150 Salem, OR 97309 Hotline: 1-888-FRAUD01 (888-372-8301) Fax: 503-373-1525 Attn: Hotline https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx CareOregon must include the above contact information for DHS Fraud Investigation Unit in its FWA Prevention Handbook and its Member Handbook.	
12	Provisions that provide detailed information about the State and federal False Claims Acts and other applicable State and federal laws, including, as provided for section 1902(a)(68) of the Social Security Act and the protections afforded to those persons who report FWA under applicable whistleblower laws. The disclosures described in subparagraph (12) are required for CareOregon only if it receives or makes payments of at least five million dollars ($5,000,000) annually as a result of its performance under the Contract.	• Federal and State False Claims, Antikickback, and Stark Law Compliance
13	Procedures to routinely verify whether services that have been represented to have been delivered by Participating Providers were received by Members. Such verification must be made by: (i) mailing service verification letters to Member (“Service Verification Letters”), (ii) sampling, or (iii) other methods.	• Verification of OHP Services

14	A system to receive, record, and respond to compliance questions, or reports of potential or actual noncompliance from employees, Providers, Subcontractors, and Members, while maintaining the confidentiality of the person(s) posing questions or making reports.	• Reporting Suspected Compliance, FWA or HIPAA Concerns
15	Provisions for CareOregon to self-report to OHA an Overpayment it received from OHA under the CCO Contract, or any other contract, agreement, or MOU entered into by CareOregon and OHA. The foregoing reporting provision must include the obligation to report, as required under 42 CFR §401.305 such Overpayment to OHA within sixty (60) days of its identification.	• Medicaid Overpayment Identification and Reporting
16	Provisions for CareOregon to report to OHA any Overpayments made to providers, Subcontractors, or other third parties, regardless of whether such Overpayment was made as a result of the self- reporting by a Provider, Subcontractor, or other third-party, or identified by CareOregon and regardless of whether such Overpayment was the result of a FWA or accounting error. If identification of Overpayment was the result of self-reporting to CareOregon by a Provider, Subcontractor, other third-party, such foregoing reporting provision must include the obligation to report, as required under 42 CFR §401.305, such Overpayment within sixty (60) days of the Provider's, Subcontractor's, or other third- party's identification of the Overpayment. If Overpayment was identified by CareOregon as a result of an audit or investigation, such Overpayment must be reported to OHA promptly, but in no event more than seven (7) days after identifying such Overpayment. If CareOregon suspects an Overpayment identified during an audit or investigation is due to FWA, such Overpayment must be reported in accordance with Exhibit B, Part 9, Section 17 of the CCO Contract. All such reports made by the Provider, Subcontractor, or other third-party must include a written statement identifying the reason(s) for the return of the Excess Payment.	• Medicaid Overpayment Identification and Reporting • CareOregon Provider Manual
17	In addition to the procedures for reporting required under #11 above, a procedure for accurately reporting on the quarterly and annual Financial Reports required under Exhibit L, Section 1(a)(2) of the CCO Contract, all Overpayments, identified or recovered regardless of whether the Overpayments were the result of (i) self-reporting under #15 and #16 above, or (ii) the result of a routine or planned audit or other review.	• Medicaid Overpayment Identification and Reporting

18	A process for Members to report FWA anonymously and to be protected from retaliation under applicable whistleblower laws.	• JCC Member handbook • CPCCO Member handbook
19	Procedures for prompt notifications to OHA when CareOregon receives information about changes in a Member's circumstances that might impact eligibility, including: (i) changes in a Member's residence, and (ii) death of a Member.	• Medicaid Enrollment
20	A procedure pursuant to which CareOregon shall provide OHA with Administrative Notice of any information it receives about a change in a Provider's circumstances that may affect the Provider's eligibility to provide services on behalf of CareOregon or any other CCO, including the termination of the Provider agreement, and such Administrative Notice must be made within thirty (30) days of receipt of such information. When the termination of a Participating Provider is for-cause, Administrative Notice must be provided to OHA's Provider Enrollment Unit within fifteen (15) days of termination, with a statement of the cause (CCO Contract Ex B, Part 4 (5)(k)).	• Termination and Suspension of Contracted Providers
Other Contract Provisions		
1	CareOregon will disseminate the FWA Prevention Handbook to all employees in accordance with the dissemination schedule listed within the FWA Handbook.	Adoption and Dissemination section above
2	The Member Handbook will include the following information relating to FWA: • A statement or narrative that articulates CareOregon's commitment to: (i) preventing FWA, and (ii) complying with all applicable laws, including, without limitation, the State's False Claims Act and the federal False Claims Act; • Examples of FWA • Where and how to report FWA; and • A Member's right to report FWA anonymously, and to be protected under applicable Whistleblower laws.	• JCC Member handbook • CPCCO Member handbook

Policies and Procedures of the FWA Handbook

Title: CCO - Ethics and Compliance Program		Version: 7	Ref #: 738
Owner: Christian Zorn (Vice President, Audit and Compliance)			
Approved by ELT/CEO: 01/29/2024	Effective Date: 04/25/2013	Next Review: 01/29/2025	
Applies to *(check all that apply)*: ☐ *Medicare* ☒ *Medicaid* ☐ *Housecall Providers* ☐ *CareOregon Corporate*			

CCO ETHICS AND COMPLIANCE PROGRAM

Purpose

The CCO's Board of Directors have adopted this Ethics and Compliance Program (the Program) to articulate the CCO's longstanding commitment to support the provision of comprehensive physical, dental, and behavioral health services through our participating providers and in compliance with all applicable federal and state laws and regulations; to prevent, detect, and guard against fraud, waste, and abuse (FWA) and non-compliance, particularly as they relate to the Oregon Health Plan (OHP). The Program, along with supporting policies and procedures for FWA prevention and reporting, and other corporate documents, is the foundation which was established to proactively prevent, detect, correct, and report variances from the laws and regulations which govern the organization; and, to ensure compliance with the CCO contract. In addition, the Program supports the promotion of an organizational culture that encourages ethical conduct and places the highest value on integrity in the achievement of its mission.

Definitions

Employee(s): includes the following – all full- and part-time employees, all temporary and contracted employees, volunteers, all casual employees, and all paid or unpaid interns.

Whistleblower: An individual who brings an action for violation of the False Claims Act in the name of the government.

Policy

The Program has been designed to address the elements identified by the Federal Sentencing Guidelines, the Office of Inspector General of the U.S. Department of Health and Human Services, and the Oregon Health Authority (OHA) CCO contract obligations[1]

[1] CCO Contract Exhibit B Statement of Work, Part 9 Program Integrity

that are required for the implementation of an effective compliance and ethics program. The formality and scope of the Program, including its standards and procedures, have been developed taking into consideration the size and complexity of the organization.

COMPLIANCE PROGRAM OVERSIGHT

The CCO Board of Directors is responsible for the reasonable oversight of the Program with respect to its implementation and effectiveness and shall be knowledgeable about its content and operation. The board of directors has designated the CCO Compliance Officer to implement and to provide regular monitoring of the Program. The CCO Compliance Officer is delegated sufficient authority and adequate resources to undertake and comply with these responsibilities, has open access to senior management including the board of directors, and reports to the CCO CEO and Board of Directors at least quarterly on the effective implementation of the Program.

The CCO Compliance Officer, ensures adequate resources are designated to perform the daily functions of the Program. The compliance committee of the CCO Board serves as the CCO Compliance Committee for the organization.

ETHICS AND COMPLIANCE STANDARDS

The ethical principles and standards of business practice that guide operations are summarized in the Code of Conduct. Each Employee, member of the board of directors, subcontractor, business associate, and participating provider is responsible for supporting an environment that encourages ethical and compliant conduct and fosters reporting behavior inconsistent with the Code of Conduct.

In addition to the Code of Conduct, the CCO has implemented policies and procedures that describe the internal controls by which management exercises due diligence in seeking not only to reduce the likelihood of criminal conduct, but to facilitate compliance with all applicable laws and prevent and detect any behavior contrary to those principles. The objectives of those policies and procedures, along with the Code of Conduct are to:

- Establish the expectation of high values;
- Provide comprehensive compliant guidelines and standards for the provision of our services;
- Monitor the implementation of those guidelines and standards;

- Enhance a corporate culture which supports compliance with federal and state statutes and regulations; and,
- Build community trust as a coordinated care organization.

These policies and procedures will be reviewed annually and periodically updated to address new or modified requirements as needed.

COMPLIANCE AND FWA

The Program and related FWA activities are based on the seven (7) core elements of an effective compliance program as identified by the Health & Human Services (HHS) Office of Inspector General (OIG).

All Employees, members of the board of directors, subcontractors, business associates, and participating providers are required to adhere to the Code of Conduct, which outlines good business conduct and compliance with the terms and conditions in Sections 1-18 of Exhibit B, Part 9 and all other applicable State and federal laws. Specific procedures related to FWA prevention and detection are outlined in the FWA Handbook.

As part of the Program, the CCO is committed to cooperating with any CMS, OHA, or other government related audit requests, as well as any entity acting on behalf of the federal government, OHA, or CMS to conduct audits. As such, the CCO agrees to provide full access to necessary records to the auditors.

ELEMENT I - Written Policies, Procedures and Standards of Conduct

The CCO has written policies, procedures, and standards of conduct that:

- Articulate the commitment to comply with all applicable federal and state standards;
- Describe compliance expectations as embodied in the Code of Conduct;
- Implement the operation of the Program;
- Provide well publicized guidance to Employees, members of the board of directors, subcontractors, business associates, participating providers and members and others on dealing with suspected, detected or reported compliance or FWA issues;
- Identify how to report compliance or FWA issues to appropriate personnel;
- Describe how suspected, detected, or reported compliance or FWA issues are

investigated and resolved; and,

- Include a policy of non-retaliation for good faith participation in the Program and related FWA monitoring activities including, but not limited to, reporting potential issues, investigating issues, monitoring, auditing, and remediation efforts, and reporting obligations to appropriate officials.

Policies and Procedures

The CCO has developed policies to describe the operationalization of the Program, including:

- Compliance and FWA training requirements;
- Reporting mechanisms including the Hotline;
- How suspected, detected, or reported potential compliance and FWA issues are investigated, addressed, and resolved; and,
- Policies are updated as needed to incorporate any changes in applicable laws, regulations, and other Program requirements.

Distribution of Compliance Policies and Procedures and Standards of Conduct

Program policies, including the *Federal and State False Claims, Anti-kickback, and Stark Law Compliance Policy*, the Code of Conduct, and the FWA Handbook, are distributed to Employees, members of the board of directors, subcontractors, business associates, and participating providers within 90 days of hire or at time of contracting and distributed annually thereafter.

ELEMENT II: Compliance Officer, Compliance Committee and High-Level Oversight

The CCO Compliance Officer is tasked with implementing and providing regular monitoring of the Program. The CCO Compliance Officer reports directly to the CCO CEO and has direct access to the CCO Board of Directors.

- The CCO Compliance Officer is a full-time employee.
- The compliance officer reports quarterly to the CCO Board of Directors on the activities and status of the Program including issues identified, investigated, and

resolved by the compliance department.

- The CCO Board of Directors have been educated on and are knowledgeable about the content and operation of the Program and exercise reasonable oversight regarding the implementation and effectiveness of the Program.

Compliance Officer

The CCO's Compliance Officer has the authority to provide unfiltered, in-person reports to the CCO's CEO and Board of Directors at their discretion. The CCO Compliance Officer is integrated into the organization and is given the credibility, authority, and resources necessary to operate a robust and effective Program. The CCO Compliance Officer is free to raise compliance issues without fear of retaliation. The CCO Board of Directors must approve any request for the termination of the CCO Compliance Officer.

Duties of the CCO Compliance Officer may include, but are not limited to:

- Ensuring compliance and FWA reports are provided regularly to the CCO Board of Directors, CCO CEO, compliance committee, and the senior management team. Reports will include the status of the Program implementation, the identification and resolution of suspected, detected, or reported instances of non-compliance, and compliance oversight and audit activities.
- Managing the department responsible for the daily activities related to the implementation of the Program including a director, managers, supervisors, and support personnel who are knowledgeable about the provision of medical assistance[2], Oregon regulations and OARs applicable to CCOs and the Oregon Health Plan (OHP), the operations of health care providers, and dedicated to and responsible for, implementing the Annual FWA Prevention Plan. The department consists of staff with differing areas of expertise and certifications such as Certifications in HealthCare Compliance (CHC) and Certified Fraud Examiner (CFE).
- Attracting and engaging high quality diverse talent by inspiring a culture of personal growth and professional development. This includes ensuring appropriate personnel continue to maintain or obtain certifications and/or continuing

[2] Under Title XIX of the Act

education designed to support the work they perform.

- Creating the Annual FWA Prevention Plan while developing and implementing the written policies and procedures set forth in the OHA Contract.
- Being aware of daily business activity by interacting with the operational units;
- Creating and coordinating educational training programs to ensure that Employees, members of the board of directors, subcontractors, business associates, and participating providers are knowledgeable about the Program, its written standards of conduct, compliance and FWA P&Ps, and all applicable statutory and regulatory requirements;
- Developing and implementing methods and programs that encourage Employees to report potential non-compliance and FWA without fear of retaliation;
- Maintaining compliance reporting mechanisms and closely coordinating with the internal audit department;
- Responding to reports of potential FWA, including the coordination of internal investigations and the development of appropriate corrective or disciplinary actions, when necessary;
- Ensuring that the Office of Inspector General (OIG), List of Excluded Individuals (LEIE), and System of Award Management (SAM) exclusion list has been checked at time of hire or contracting with and monthly thereafter for all Employees, members of the board of directors, subcontractors, business associates, and participating providers and coordinating any resulting personnel issues with human resources or other departments as appropriate;
- Maintaining documentation for each report of potential non-compliance or FWA received from any source, through any reporting method (e.g., Hotline, mail, or in-person);
- Overseeing the development and monitoring of the implementation of corrective action plans;
- Periodically providing reports of risk areas facing the CCO, the strategies being implemented to address them, and the results of such strategies;

- Coordinating potential fraud investigations or referrals with the appropriate governing authority such as the Medicaid Fraud Control Unit (MFCU) of the Oregon Department of Justice (DOJ), and OHA Office of Program Integrity (OPI); and, facilitating any documentation or procedural requests received from the MFCU; and,
- Assessing the overall effectiveness of the Program and taking steps to enhance it based on information learned in a process of continual improvement.

CCO management recognizes that the CCO Compliance Officer must have sufficient independence, credibility, authority, and resources to promote a culture of compliance and to achieve an effective and meaningful Program. As such, among other things, the CCO Compliance Officer (or delegate) has authority to:

- Interview Employees and other relevant individuals;
- Review Medicaid contracts and other documents pertinent to the Medicaid program;
- Review and validate the submission of data to OHA to ensure that it is accurate and in compliance with OHA reporting requirements;
- Independently seek advice from legal counsel;
- Report potential FWA to the MFCU and OPI, its designee or law enforcement;
- Conduct and/or direct audits and investigations of any subcontractors or vendors;
- Acquire or seek individuals, through consultant or other contractual arrangements, with forensic or specialized skills to support the investigation of cases, when needed;
- Conduct and/or direct audits of any area or function involved with the Medicaid program; and,
- Recommend policy, procedure, and process changes.

<u>CCO Board of Director Compliance Committee</u>

The CCO has established a multi-disciplinary board-level regulatory compliance committee to address compliance and FWA considerations associated with the Program. The committee is responsible for the oversight, implementation, and overall effectiveness of the Program, related FWA activities, and compliance with the terms and conditions of the OHA CCO contract.

The committee includes the CCO's Compliance Officer, senior level management, and at least two members of the CCO's Boards of Directors. The primary function of the committee is to assist the board of directors in assuring that the CCO and its delegated entities are operating according to their contractual responsibilities. The committee reviews and approves the Program; receives and reports on Program related activities; and monitors the monthly compliance dashboards to evaluate ongoing operational performance.

The CCO Compliance Officer and CEO shall include additional personnel in this committee as needed. Working in conjunction with the CCO Compliance Officer, the duties of the committee include the following:

- Meeting at least once a quarter, or more frequently as necessary, to receive updates of compliance activities and to support and evaluate compliance and FWA concerns of any potential or actual violations;
- Assisting with the implementation of the compliance and FWA risk assessment of the compliance and FWA monitoring and auditing work plan;
- Ensuring new or updated Medicaid and OHA contract requirements are implemented timely;
- Assisting in the timely implementation and monitoring of corrective actions;
- Developing innovative ways to implement corrective and preventative actions;
- Reviewing effectiveness of the system of internal controls designed to ensure compliance with Medicaid regulations performed daily by operations;
- Using quantitative measurement tools (e.g., scorecards, dashboard reports, key performance indicators) to report, track, and compare over time, compliance with key OHA requirements including, but not limited to, enrollment, appeals and grievances, and prescription drug benefit administration;

- Supporting the CCO Compliance Officer's needs for sufficient staff and resources to carry out their Program duties;
- Annual approval or review of the Code of Conduct, CCO Ethics and Compliance Program, Committee Charter, and Annual Audit Schedule;
- Applying consistent, timely, and appropriate disciplinary action, when needed;
- Remaining informed about governmental compliance enforcement activity; and,
- Ensuring the CCO has a system to receive, record, and respond to compliance and FWA questions or reports of actual or potential non-compliance and FWA from Employees, members of the board of directors, subcontractors, business associates, participating providers, and members while maintaining the confidentiality of the person(s) posing questions or making reports made in good faith – including anonymously – without fear of retaliation.

Senior Management Program Responsibilities

The CCO's senior management and CEO are knowledgeable of and fully supportive of the Program and related FWA activities. Senior management is responsible for ensuring daily operational activities are performed in compliance with all applicable federal and state laws and regulations and OHA CCO contractual responsibilities through ongoing self-monitoring activities. They have an obligation to report any potential or actual non-compliance and FWA concerns to the CCO Compliance Officer (or applicable delegate) related to the Program. Senior management shall direct their staff to support the Program including: the reporting of any potential or actual non-compliance and FWA concerns; the timely completion of implementation and/or remediation efforts related to applicable federal and state laws and regulations and/or OHA CCO contractual obligations. Senior management serves as a key example of a culture of compliance and ethical behavior including ensuring a culture of non-retaliation.

ELEMENT III: Effective Training and Education

Compliance and FWA training are a key component of the Program and related FWA prevention, detection, and correction activities. Compliance training, including FWA and Health Insurance Portability and Accountability Act (HIPAA), is provided to all Employees,

members of the board of directors, subcontractors, and participating providers as part of to ensure they understand the CCO's commitment to ethical behavior and compliance, including the proactive detection, investigation, and reporting of FWA. The CCO ensures appropriate training is provided to Employees and members of the board of directors to ensure they are aware of federal and state laws and regulations and the OHA CCO contract requirements related to their job functions.

Compliance and FWA Training

All company Employees and members of the board of directors participate in compliance and FWA training within ninety (90) days of initial hire/appointment and annually thereafter.

The CCO satisfies compliance training requirements by:

- Conducting in-person/virtual, classroom based new hire compliance and FWA training;
- Performing annual compliance and FWA training through use of our Online Learning Commons (CareU) training platform; and,
- Requiring Employees and members of the board of directors to acknowledge that they have received the Code of Conduct; *Federal and State False Claims, Anti-kickback, and Stark Law Compliance Policy*, and the FWA Prevention Handbook.

Initial compliance training is conducted by the CCO Compliance Officer (or designee) and covers the core compliance and FWA prevention topics listed below:

- A description of the Program, including FWA prevention, detection, correction, and articulation of the CCO's commitment to business ethics and compliance with all applicable state and federal laws and regulations;
- The process to ask questions or to report compliance and FWA concerns, including a description of the compliance Hotline and other reporting mechanisms that are available to Employees, members of the board of directors, subcontractors, business associates, and participating providers who wish to report actual or potential compliance or FWA violations directly or anonymously;
- The requirement to report to the CCO Compliance Officer (or designee) any

incident of potential or actual non-compliance or FWA immediately;

- Requirements around HIPAA/HITECH and the importance of maintaining the privacy and security of personal health information;
- Examples of reportable non-compliance and FWA that an Employee or member of the board of directors might observe are discussed during *Compliance and FWA* training and covered in detail in the FWA Handbook policies and procedures, and Code of Conduct;
    - This includes but not limited examples such as those referenced in the OHA CCO Contract Exhibit B Part 9 and the CCOs obligation to refer any FWA cases to OHA within seven (7) days after receiving the information.
- A review of the disciplinary guidelines for non-compliant or FWA behavior. The guidelines communicate how such behavior can result in mandatory retraining and may result in disciplinary action, up to and including possible termination when such behavior is serious or repeated or when knowledge of a possible violation is not reported;
- Notification that attendance and participation in *Compliance and FWA* training is a condition of continued employment;
- Review of issues related to contracting with the government, including pertinent laws addressing FWA, such as the Anti-Kickback Statutes, Stark Law, and the False Claims Act; and,
- An overview of the monitoring and auditing process.

The CCO's compliance expectations are communicated to participating providers (via contract language and the Provider Handbook) and subcontractors (via contract language and the FWA Handbook) as well as at the time of contracting through distribution of our Code of Conduct and onboarding training, which includes examples of FWA and the obligation to report any instances that include characteristics of FWA to CCO promptly but no later than three (3) days after discovered, this ensures the CCO will meet the seven (7) day reporting requirement to the appropriate State authority.

The compliance and FWA training materials are reviewed and updated, as necessary, whenever there are changes in regulations, policy, or guidance, and at least annually.

The CCO contract requires all subcontractors to certify that their Employees, members of the board of directors, subcontractors, and business associates participated in general compliance and FWA training; and appropriate education and training to prevent, detect, and correct potential FWA within the ninety (90) days of employment and at least annually thereafter.

ELEMENT IV: Effective Lines of Communication

The CCO has established and implemented effective lines of communication that are intended to encourage and promote honest, effective, and efficient working relationships between the CCO Compliance Officer, members of the compliance committee, Employees, members of the board of directors, subcontractors, business associates, participating providers, and members. These lines of communication allow suspected compliance and FWA concerns to be reported, including a method for anonymous and good faith reporting of issues.

The CCO has an effective mechanism to communicate information between the CCO Compliance Officer and others and includes the CCO Compliance Officer's name, floor location and contact information (phone number and email address). This information is communicated in the *Compliance and FWA* training materials and is readily available through multiple electronic resources throughout the organization.

Communication and Reporting Mechanisms

The Code of Conduct and P&Ps require all Employees, members of the board of directors, subcontractors, business associates, participating providers, and members to report compliance concerns and suspected or actual violations related to the Program to the CCO Compliance Officer (or designee).

The CCO uses EthicsPoint to receive, record, respond, and track compliance questions or reports of suspected or detected non-compliance or potential FWA from Employees, members of the board of directors, subcontractors, business associates, participating providers, and members. EthicsPoint maintains anonymity (to the greatest extent possible) as requested and emphasizes the CCO's policy of non-retaliation for good faith reporting of compliance and FWA concerns.

The CCO has adopted and enforced a widely publicized policy of no tolerance for retaliation against any Employee, member of the board of directors, subcontractor, business associate, participating provider, and/or member who reports suspected non-compliance or FWA concerns in good faith.

The methods available for reporting compliance or FWA concerns, and the non-retaliation policy are publicized throughout the CCO's facilities. This information is displayed on awareness flyers posted in the kitchen areas on each floor and includes a pull-away note that includes the phone number and web address for EthicsPoint for Employees to use to report actual or suspected FWA.

The CCO makes the reporting mechanisms user friendly, easy to access and navigate, and available 24 hours a day for Employees, members of the boards of directors, subcontractors, business associates, participating providers, and members.

When a suspected compliance issue is reported, the compliance officer (or designee) provides the complainant with information regarding expectations of a timely response, non-retaliation, and progress reports.

If any Employee, member of the board of directors, subcontractor, business associate, participating provider, and/or member knows or suspects that FWA or a compliance issue has occurred, they have an affirmative obligation to report the incident(s). A report can be made in the following methods:

- Contact the CCO Compliance Officer:
  Attn: Chris Zorn / Compliance Officer
  315 SW Fifth Avenue, Suite 200
  Portland, Oregon 97204
  503-416-4700

- Contact EthicsPoint, our secure anonymous reporting vendor at EthicsPoint - CareOregon, Inc. or calling the EthicsPoint toll-free Hotline at 888-331-6524, available any time, 24 hours a day, 7 days a week.

Member Communication and Education

The CCO educates our Medicaid members about identification and reporting of potential compliance and FWA issues. This material is included in the member handbook and stored on the CCO website.

ELEMENT V: Well-Publicized Disciplinary Standards

CCO has well-publicized disciplinary standards through the implementation of procedures which encourage good faith participation in the Program. These standards include policies that:

- Articulate expectations for reporting compliance issues and assist in their resolution;
- Identify non-compliance or unethical behavior; and
- Provide for timely, consistent, and effective enforcement of the standards when non- compliance or unethical behavior is determined.

Disciplinary Standards

All Employees, members of the board of directors, subcontractors, business associates, and participating providers are held accountable for failing to comply with relevant laws, regulations, CCO contract requirements, and the Program including all applicable policies and procedures.

Employees, members of the boards of directors, subcontractors, business associates, and participating providers are informed that compliance violations may result in disciplinary action, up to and including termination of employment or contract. Disciplinary actions that can be imposed for non-compliance may include oral or written warnings or reprimands, suspensions, or terminations. Any Employee, member of the board of directors, subcontractor, business associate, and participating provider who fails to report known or suspected violations by another may also be subject to disciplinary actions. Disciplinary actions may be imposed even if no violation has occurred, if otherwise deemed appropriate by the circumstances.

The disciplinary determination will be based upon the facts and circumstances of each violation or misconduct. If an Employee, member of the board of directors, subcontractor, business associate, and participating provider has committed fraud, waste, abuse, violated

federal or state laws, or failed to comply with the Program or Code of Conduct, that Employee, member of the board of directors, subcontractor, business associate, and participating provider shall be the subject to appropriate disciplinary actions based on the particular issue and as determined by the Employee's immediate manager, human resources, compliance, with input from the CCO Compliance Officer, as needed.

The CCO strictly prohibits retaliation against an Employee, member of the board of directors, subcontractor, business associate, participating provider, or member who, in good faith, reports known or suspected violations. Any person taking retaliatory action against an Employee, member of the board of directors, subcontractor, business associate, participating provider, or member, who in good faith filed a report, will be subject to disciplinary action, up to and including termination of employment or contract.

The CCO shall provide detailed information about the state and federal False Claims Acts and other applicable state and federal laws, including, as provided for section 1902(a)(68) of the Social Security Act and the protections afforded to those persons who report Fraud, Waste, and Abuse under applicable whistleblower laws. This disclosure is a requirement of CCO since we receive and make payments of at least five million dollars ($5,000,000) annually as a result of its performance under the OHA CCO Contract.

Methods to Publicize Disciplinary Standards

To encourage good faith participation in the Program, the CCO publicizes disciplinary standards for Employees, members of the boards of directors, subcontractors, business associates, and participating providers. The standards include the duty and expectation of all Employees, members of the board of directors, subcontractors, business associates, and participating providers to report issues or concerns. The CCO uses the following types of publication mechanisms to encourage good faith participation in the Program:

- Compliance and FWA training; and
- Compliance and/or FWA flyers prominently displayed in break areas.

The CCO maintains records for a period of 10 years for all compliance violation disciplinary actions, capturing the date the violation was reported, a description of the violation, dates

of the investigation, summary of findings, and a description of any disciplinary action taken and the date it was taken.

ELEMENT VI: Effective System for Routine Monitoring, Auditing, and Identification of Compliance Risks

The CCO has implemented an internal monitoring and auditing plan to evaluate compliance with Medicaid program requirements on an ongoing basis; to assess overall effectiveness of the Program; to protect the Medicaid program and beneficiaries from FWA; and to mitigate the liability of the CCO resulting from FWA activities. Procedures are intended to test and confirm compliance with the regulations governing the Medicaid program and other applicable legal requirements, guidance published by OHA and CMS, contractual requirements, and CCO policies.

Routine Monitoring and Auditing

The CCO performs monitoring and auditing to confirm compliance with state and federal laws and rules and the OHA CCO contract. Monitoring is related to internal policies and procedures to protect against Medicaid program non-compliance and potential FWA.

Operations is responsible for monitoring routine activities to confirm ongoing compliance and to ensure that necessary corrective actions are implemented and effective. An example of monitoring includes evaluating a compliance dashboard with metrics based on requirements related to state and federal laws and regulations or the OHA CCO contract.

The CCO has developed a system of routine monitoring to evaluate compliance with state and federal laws and regulations and the OHA CCO contract requirements. These components consist of:

- Each functional department manager is accountable for compliance with federal and state requirements including FWA activities. Department leadership is responsible to develop and implement ongoing monitoring processes to ensure compliance with applicable requirements. All issues of non-compliance and FWA are to be immediately reported to the CCO Compliance Officer (or designee).
- Accuracy and timeliness metrics have been identified and are routinely collected, reported, reviewed, and trended for select functional areas, on a monthly basis.

Any areas of concern will receive follow-up;

- Procedures to routinely verify whether services that have been represented to have been delivered by network providers were received by Medicaid members; or where a Medicaid member has paid out of pocket for services, and collect any associated overpayments (Please see *Verification of OHA Services Policy and Procedures* for details)

- A risk assessment will be performed on an annual basis considering mulitple factors including – but not limited to – the OHA, CMS, and OIG guidance, past performance, environmental issues, impact to the member to identify areas where audits will be performed; and

System to Identify Compliance Risks

In developing the annual compliance work plan, the CCO Compliance Officer will determine the appropriate priorities by evaluating a variety of factors, including:

- Internal and external audit results;

- Management and other monitoring reports and activities; feedback from the compliance committee, senior management, and select Employees, gathered through an interview and survey process, as described in the *Enterprise Risk Assessment Policy*.

- OIG guidance and other documents, including the OIG's work plan; and

- Feedback from OHA and CMS central or regional office representatives.

Annual Work Plans

The CCO Compliance Officer along with their departmental staff will collect, compile, and evaluate the results of the annual risk assessment to determine the annual work plan, including compliance and FWA audits, for the next calendar year. The work plan is subject to changed based on changing risk evaluation. Each audit will be evaluated for timing, scope, and duration. The proposed annual audit plan will be presented to CCO Board of Directors for review.

Monitoring and Auditing Subcontractors

Subcontractors are responsible for the lawful and compliant administration of the Medicaid program including but not limited to Exhibit B Part 4 Section 11.

The subcontractor business owner is responsible for routine monitoring of their subcontractors in order to confirm ongoing performance. The business owner is responsible to promptly report any potential or actual non-compliance or FWA concerns to the CCO Compliance Officer (or designee).

An annual risk assessment of subcontractors is conducted by the CCO Compliance Officer or their department staff to develop the annual work plan for the next calendar year. Each subcontractor is audited based on the OHA CCO contract requirements including Exhibit B Part 9 Sections 11-18.

OIG/SAM (formally GSA) Exclusions

The CCO will not employ or contract with any entity or individual that is excluded from receiving monies from a federally funded program. As such, the CCO will not use federal or state funds to pay for services, equipment or drugs prescribed, or provided by a subcontractor, business associate, or provider excluded by the Department of Health and Human Services (DHHS) Office of the Inspector General (OIG).

Monthly screening is essential to prevent inappropriate payment to providers, pharmacies, subcontractors, and other entities that have been added to exclusions lists since the last time the list was checked.

Regulator Audits

Under the direction of the CCO Compliance Officer, the CCO will fully cooperate with external audits performed by OHA and CMS, state insurance departments, law enforcement agencies, or any auditor acting on behalf of the federal or state government. The CCO Compliance Officer will coordinate all internal activities relating to external regulator related audits.

ELEMENT VII: Procedures and System for Prompt Response to Compliance Issues

The CCO has established and implemented policies and procedures and a system for promptly responding to compliance and FWA issues as they are raised, investigating potential compliance and FWA problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence and ensuring ongoing compliance with applicable state and federal laws and regulations and the OHA CCO contract requirements.

- If the CCO discovers evidence of misconduct related to payment or delivery of items or services under the contract, we will conduct a timely, reasonable inquiry.
- The CCO must report all suspected Medicaid cases of FWA, including suspected fraud committed by its Employees, members of the board of directors, subcontractors, business associates, participating providers, and members or any other third parties to OHA's OPI and Oregon's DOJ's MFCU. Reporting shall be made promptly but in no event more than seven calendar (7) days after the CCO is initially made aware of the suspicious case. All Medicaid reporting must be made as set forth by the OHA CCO contract.
- The CCO conducts appropriate corrective actions (such as, repayment of overpayments, disciplinary actions against responsible individuals) in response to the potential violation referenced.
- Provisions for the CCO to self-report to OHA any overpayment it received from OHA under this Contract, or any other contract, agreement, or MOU entered into by Contractor and OHA. The foregoing reporting provision must include the obligation to report, as required under 42 CFR §401.305. Overpayment reporting/reimbursements to OHA needs to occur within sixty (60) days of its identification.

<u>Conducting a Timely and Reasonable Inquiry of Detected Offenses</u>

The CCO conducts timely and well-documented reasonable inquiries into any compliance incident or issue involving potential Program non-compliance or potential FWA.

Program non-compliance and FWA may occur at the CCO, subcontractor, participating provider, or member. It may be discovered through a Hotline, a website, a member complaint, during routine monitoring or self-evaluation, an audit, or by regulatory

authorities. Regardless of how the non-compliance or FWA is identified, the CCO will initiate an inquiry, but no later than seven (7) calendar days after the date the potential non-compliance or potential FWA incident was reported. The SIU team partners with individual business units and are responsible for monitoring of FWA. When potential FWA activity is identified, the SIU will report the issue according to the CCO Contract requirements and the report will be submitted to the appropriate investigative department.

Corrective Action

The CCO will undertake appropriate corrective actions in response to potential non-compliance or potential FWA.

The corrective actions will be designed to remediate the underlying problem that resulted in non-compliance and to prevent future incidents. A root cause analysis will be conducted to determine what caused or allowed the issue of non-compliance or FWA. Internal controls will be evaluated to determine more appropriate measures. The corrective action will be tailored to address the particular non-compliance or FWA deficiency identified and will include expected completion dates. Whenever possible, short-term mitigation efforts will be taken to stop the non-compliant or FWA issue as quickly as possible.

The CCO must ensure that subcontractors, business associates, and participating providers have corrected any deficiencies. When developing corrective actions for FWA or non-compliance by a subcontractor, the elements of the corrective action will be detailed in writing and include any actions that will be taken if the subcontractor fails to implement the corrective action satisfactorily. Subcontractor contracts shall include language that details the actions that will be taken for failing to maintain compliance or engaging in FWA, up to an including contract termination.

The elements of the corrective action that address non-compliance or FWA committed by CCO's Employee(s), member(s) of the board of directors, subcontractor(s), business associate(s), and participating provider(s) must be documented, and include any disciplinary actions should the Employee(s), member(s) of the board of directors, subcontractor(s), business associate(s), and participating provider(s) fail to satisfactorily implement the corrective action. The CCO will enforce effective corrective action through disciplinary measures, including employment or contract termination, if warranted.

Procedures for Self-Reporting Potential FWA and Significant Non-Compliance

The CCO will comply with the self-reporting requirements for the Medicaid program FWA and significant non-compliance events.

The CCO actively investigates potential FWA activity to make a determination whether FWA has occurred and concludes investigations timely after the activity is discovered. The SIU team reviews the potential FWA report related to the Medicaid program, if any characteristics listed in CCO Contract as FWA are identified the matter will be referred to the MFCU/OPI within seven (7) days. The CCO will also refer potential subcontractor FWA, as appropriate.

When the CCO discovers an incident of significant Medicaid program non-compliance, compliance will report the incident to MFCU/OPI within seven (7) calendar days. This will enable OHA to provide guidance to the CCO on mitigation of the harm caused by the incident of non-compliance.

Self-reporting offers the CCO the opportunity to minimize the potential cost and disruption of a full-scale audit and investigation, to negotiate a fair monetary settlement, and to potentially avoid an OIG permissive exclusion preventing the entity from doing business with federal health care programs.

Please see the *SIU Investigations and Reporting of suspected FWA Policy and Procedure* for more detailed information.

Identifying Providers with a History of Complaints

The CCO will maintain files for a period of 10 years on both in-network and out of network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes enrollee complaints, MEDIC investigations, OIG and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of federal health care program requirements. The CCO will also maintain files that contain documented warnings (i.e., fraud alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. The CCO will comply with requests by law enforcement, OHA, CMS and CMS' designee regarding monitoring of providers within the sponsor's network that CMS or OHA has identified as potentially abusive or fraudulent.

Title: Compliance and FWA Training		Version: 6	Ref #: 231
Owner: Christian Zorn (Vice President, Audit and Compliance)			
Approved by ELT/CEO: 01/29/2024	Effective Date: 04/09/2013	Next Review: 01/29/2025	
Applies to *(check all that apply)*: ☒ *Medicare* ☒ *Medicaid* ☒ *Housecall Providers* ☒ *CareOregon Corporate*			

Scope:

This Policy is applicable to all CareOregon Employees and all CareOregon subsidiaries or affiliated entities including but not limited to Health Plan of CareOregon, Inc., Columbia Pacific CCO, LLC, Jackson County CCO, LLC, Housecall Providers Services, LLC, Housecall Providers, PC, and Care Access, LLC.

Purpose:

To define the policy and process by which CareOregon[1] ensures that all employees, members of the Board of Directors, subcontractors and FDRs receive effective Compliance and FWA training and education. Compliance and FWA training will assist CareOregon in being compliant with all applicable CMS guidance and regulations, State, and contract requirements as well as assist in fraud, waste and abuse and compliance detection, correction, and prevention efforts. This P&P is in accordance with the CCO contract requirements, including Exhibit B, Part 9(11)(b)(7) and additional requirements in accordance with 42 CFR §§438.608(a), 42 C.F.R. §§ 422.503(b)(4)(vi)(C) and 42 C.F.R §§ 423. 423.504(b)(4)(vi)(C).

Policy:

CareOregon employees, temporary and contract employees, volunteers, members of the Board of Directors, subcontractors, business associates, First Tier, Downstream, and Related Entities (FDR) and participating providers are required to complete and acknowledge Compliance and Fraud, Waste, and Abuse (FWA) training within 90 days of initial hire or contracting, and annually thereafter. CareOregon will review its Compliance and FWA training and education programs at least annually and revise as needed.

Procedure:

Employees and Members of the Board of Directors

1. All employees[2] and members of the Board of Directors are required to complete Compliance and FWA training within their first 90 days of hire, and annually thereafter.

2. Compliance and FWA training are provided for all employees and members of the Board of Directors, within their first 90 days, to ensure that they understand the Company's

[1] When used singularly, "CareOregon" includes all lines of business, subsidiaries, and affiliated companies.
[2] "Employee" includes temporary and contract employees, casual employees, volunteers, interns (paid and unpaid)

commitment to ethical behavior and programs directed at proactive detection, prevention, investigation, reporting, and corrective action in regard to FWA and issues of non-compliance. Open discussion, questioning, and reporting of potential violations is encouraged, and training is designed so that employees and others know what is expected of them.

a. New hire training is conducted by Compliance. Training attendance records are captured in CareOregon's Online Learning Commons (CareU).
b. Topics that are addressed in new hire and annual Compliance and FWA training include the following:
    i. Federal and State laws and regulations including CMS guidance[3] and regulations, CCO contract requirements[4] (i.e., False Claims Act, Anti-Kickback statute, identifying FWA, etc.);
    ii. Processes for employees to report suspected FWA to Compliance;
    iii. Protections for employees including anonymous reporting, applicable whistleblower laws, and the Company's non-retaliation policy;
    iv. Types of FWA that can occur in workplace settings such as those related to the Medicare and Medicaid Programs; and,
    v. Information on regulatory entities such as Office of Program Integrity (OPI) and Medicaid Fraud Control Unit (MFCU), including obligation to report allegations within seven (7) days to the State.

3. All employees and members of the Board of Directors are required to complete Compliance and FWA training annually.
    a. Compliance creates and maintains the annual training within CareOregon's Online Learning Commons (CareU).
    b. Training and attendance records are captured within CareU.
    c. This training is performed in the 3rd quarter of each year. *This includes those employees who have not completed the CareOregon New Hire training for the year.*

Monitoring

1. New hire training records will be reviewed by Compliance monthly to ensure the new employees have taken their training within the 90-day requirement.

2. Annual training records are reviewed and follow up on by Compliance to ensure completion.

[3] 42 CFR 422.503(b)(4)(vi)(C)
[4] CCO Contract, Exhibit B, Part 9, 11(b)(7)-(8)

3. Failure to complete required trainings within specified timelines will result in prompt notification to the employee's direct supervisor, Human Resources, and may include disciplinary action. Disciplinary actions may include:
    a. Verbal warning
    b. Written warning
    c. Suspension from work duties

Training and Education for Employees Conducting Provider Credentialing:

1. Annually, employees responsible for provider credentialing are trained and educated on requirements related to:
    a. Ensuring that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements; and,
    b. Ensuring that CareOregon does not contract, employ, or otherwise be affiliated with any sanctioned individual.

Compliance and FWA Training for First Tier, Downstream, and Related Entities (FDRs), subcontractors, and business associates

As a contract condition, CareOregon requires all FDRs, subcontractors, and business associates to complete Compliance and FWA Training.

1. FDRs, subcontractors, and business associates receive CareOregon's Code of Conduct and Compliance and Fraud, Waste, and Abuse Training materials.
2. FDR, subcontractor, and business associate employees must complete Compliance and FWA training within the first ninety (90) days of employment/contracting with their employer, including managers, officers, and governing body directors, and must complete training annually thereafter.
    a. Training must align with the materials presented in:
        i. CMS Medicare Learning Network (http://www.cms.gov/MLNProducts).
        ii. Coordinated Care Organization contract with the Oregon Health Authority (Exhibit B, Part 9, Section 11).
3. FDRs, subcontractors, and business associates may be required to provide evidence of completed trainings on an annual basis.
    a. Failure to provide evidence will result in a corrective action.
    b. Failure to address lack of training may result in disciplinary action up to and including termination of the contract.

Compliance and FWA Training for Participating Providers

As a contract condition, CareOregon requires all Participating Providers to complete Compliance and FWA training.

1. At the time of contracting participating providers receive a copy of CareOregon's Code of Conduct; onboarding provider training, which includes Compliance and FWA information such as provider's obligation to report any instance of FWA to CareOregon within three (3) days of discovery, examples of FWA such as those referenced in Section 16 of Exhibit B Part 9 of the CCO contract, and information regarding regulatory reporting.
2. All Participating Provider employees must complete Compliance and FWA training within the first ninety (90) days of employment/contracting with their employers, including managers, officers, and governing body directors, and must complete training annually thereafter.
3. Participating Providers may be required to provide evidence of completed trainings on an annual basis.
    a. Failure to provide evidence will result in a corrective action.
    b. Failure to address lack of training may result in disciplinary action up to and including termination of the contract.

Reviewing and Updating Training Materials and Programs

At least annually, the Compliance Department will review the Company's training materials and program for all trainings referenced above and update materials to reflect changes in federal and state laws and regulations; CMS regulations and guidance for Medicare and/or Medicaid plans; Company practices; and, CCO contract obligations, including but not limited to the requirements set forth in CCO Contract Exhibit B, Part 9.

Title: Reporting Suspected Compliance, FWA or HIPAA Concerns		Version: 8	Ref #: 725
Owner: Christian Zorn (Vice President, Audit and Compliance)			
Approved by ELT/CEO: 01/29/2024	Effective Date: 11/30/2020	Next Review: 01/29/2025	
Applies to *(check all that apply)*: ☒ *Medicare* ☒ *Medicaid* ☒ *Housecall Providers* ☒ *CareOregon Corporate*			

Scope:

This Policy is applicable to all CareOregon Employees and all CareOregon subsidiary or affiliated entities including but not limited to Health Plan of CareOregon, Inc., Columbia Pacific CCO, LLC, Jackson County CCO, LLC, Housecall Providers Services, LLC, Housecall Providers, PC, and Care Access, LLC.

Purpose:

CareOregon maintains multiple communication lines and this policy identifies how employees, members of the Board of Directors, subcontractors, business associates, First Tier, Downstream, Related Entities (FDRs) and participating providers should communicate potential and/or suspected privacy, compliance, and fraud, waste, or abuse (FWA) issues and concerns.

Definitions

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

CareOregon: Includes, but not limited to; CareOregon Corporate; the affiliated CCOs Jackson Care Connect and Columbia Pacific CCO; CareOregon Advantage; CareOregon Dental; CareOregon as a service provider for both Integrated Delivery System (IDS) and Tribal contracts; and HouseCall Providers.

Employee: All full time and part time employees, all temporary employees, volunteers, all casual employees, and all interns (paid or unpaid).

FDR: First Tier, Downstream, or Related Entities (FDRs) means any party that enters into a written arrangement with a Medicare Advantage organization or Part D plan sponsor to provide administrative services or healthcare-related services.

Fraud: Knowingly and willfully executing, or attempting to execute, a scheme or ploy to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses,

representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

FWA: Fraud, waste, or abuse.

Privacy: Refers to the confidentiality of protected health information defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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

Whistleblower - An individual who brings an action for violation of the False Claims Act in the name of the government.

Source:OAR 410-120-0000, OAR 410-141-3500, 42 CFR 455.2, 42 CFR 438.2

Policy:

CareOregon provides several reporting options as well as maintains a confidential reporting hotline to receive, record, and respond to reports of suspected potential or actual non-compliance with all relevant federal and state laws and rules, including suspected FWA, and/or privacy concerns (Coordinated Care Organization (CCO) Contract, Exhibit B, Part 9, Section 11; Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines).

CareOregon publicizes and enforces a no-tolerance policy for retaliation against any employees, members of the Board of Directors, subcontractors, business associates, FDRs, participating providers and members who report in good faith suspected FWA, privacy concerns, and/or other issues or concerns of non-compliance.

Procedure:

REPORTING PROCESS

CareOregon is committed to providing an environment that encourages and provides processes for its employees to report potential or actual issues or seek and receive prompt guidance before engaging in conduct that is believed to be inconsistent with federal or state laws or regulations or our Code of Conduct.

Any potential or actual non-compliance issues identified by a CareOregon employee, member of the Board of Directors, subcontractor, business associate, FDR, or participating provider are to be immediately reported to CareOregon's Vice President (VP) of Audit & Compliance.

Reports can be made in the following ways:

1. **<u>Anyone</u> can report issues or concerns of potential compliance, privacy, or FWA:**
    a. Employees, member of the Board of Directors, subcontractor, business associate, FDR, participating providers or members should call the EthicsPoint Corporate Compliance Hotline Call Center at 1-888-331-6524 or file a report on the EthicsPoint Corporate Compliance Website (www.ethicspoint.com) and include information on the origin of the incident, member information, provider information, claim information, date and time of the incident, and other applicable information.
        i. EthicsPoint allows submitters to select the option to remain anonymous.
    b. The VP of Audit & Compliance can be reached at 503-416-4700.
    c. Email to: CareOregonComplianceDepartment@careoregon.org .
2. Employees can also use the information posted on the CareOregon intranet:
    a. The Enterprise Applications page contains links for the virtual reporting forms for:
        i. FWA (Fraud, Waste, and Abuse Icon form)
        ii. Privacy (HIPAA Breach Icon form)
    b. EthicsPoint information can be found under the Compliance Department page of the intranet including links to all forms.
    c. Employees can send an email to:
        i. **#ComplianceTeam**
        ii. **#Fraud Waste and Abuse,**
        iii. **#Breach Notification, or**
        iv. **<u>Anyone</u> within the Audit & Compliance department**
    d. Examples of potential issues that should be reported can be found at:
        i. Intranet FWA site under SIU Investigations and Reporting of suspected Fraud, Waste, and Abuse (FWA) Policy and Procedure.
        ii. Intranet Privacy site under Breach Notification Policy and Procedure.

CONFIDENTIALITY

CareOregon is obligated to investigate employee concerns and take any necessary corrective action. Materials found during the inquiry of a potential issue may be shared with the Medicaid Fraud Control Unit (MFCU), DHS Fraud Investigation, Office of Program Integrity (OPI), Office of Inspector General (OIG), CMS/MEDIC, or other regulatory entity as applicable to the concern.

1. Issues related to FWA will be handled in accordance with the SIU Investigations and Reporting of Suspected Fraud, Waste, and Abuse (FWA) Policy.
2. Issues related to potential non-compliance will be handled in accordance with the Compliance Program.
3. Issues related to potential privacy concerns will be handled in accordance with the Breach Notification Policy and Procedure.

All confidential information and records researched, obtained, and used during an inquiry are maintained by the Vice President of Audit and Compliance in accordance with federal and state laws and CareOregon policies on confidentiality.

Title: Code of Conduct		Version: 5	Ref #: 252
Owner: Christian Zorn (Vice President, Audit and Compliance)			
Approved by ELT/CEO: 03/03/2025	Effective Date: 02/14/2015	Next Review: 03/03/2026	
Applies to *(check all that apply)*: ☒ *Medicare* ☒ *Medicaid* ☒*Housecall Providers* ☒*CareOregon Corporate*			

Code of Conduct

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the controlled version published online prevails.

Table of Contents

GETTING STARTED:

Why do we have a Code of Conduct?

Our Code of Conduct is the roadmap and compass for conducting our operations ethically and in accordance with the law. It sets forth the standards that guide our actions and describes the values and ethical behavior expected by CareOregon. The Code of Conduct also contains useful guidance for daily business conduct, which is intended to assist us in our work for CareOregon. While no guidelines can cover every issue that may arise, it is our responsibility to always exercise ethical conduct. There is no substitute for personal integrity and good judgement in helping us do so.

Who must follow our Code of Conduct?

Our Code of Conduct applies to all CareOregon Employees, members of the Board of Directors, volunteers, vendors, and employees of subcontractors and downstream entities who are performing work for CareOregon. It applies to CareOregon and all of its subsidiaries and affiliated entities, including Health Share of Oregon and Housecall Providers.

What are our responsibilities?

As CareOregon, we commit to follow the guidelines set forth in this Code of Conduct. Our responsibilities include:

- Reading and being familiar with the information in our Code of Conduct.
- Certifying annually that we understand and will follow our Code.
- Acting in a manner that is consistent with our core values and ethical standards.
- Raising questions and concerns if we become aware of violations of laws or our Code; and
- Cooperating when responding to an investigation or audit.

We provide coverage to individuals enrolled in Medicaid and Medicare in Oregon. As a result, we must comply with applicable laws and regulations set forth by the State of Oregon and the Federal government. If a situation arises where our Code of Conduct, policies, or practices conflict with laws or regulation, you must contact the Compliance Team for guidance.

Additional expectations for management:

We rely on our management to promote an environment that supports our core values and compliance with the Code of Conduct. To help us maintain this environment, we expect management to:

- Serve as a positive role model for ethical behavior and decision-making.
- Help those they supervise understand our Code and behavior expected of them; and
- Create an open environment where employees are comfortable raising questions and concerns.

Managers are expected to report any known or suspected misconduct they are made aware of and not retaliate or ignore acts of retaliation against others.

What is expected of our business partners?

We expect our business partners (vendors, subcontractors, downstream entities, and other third parties) to act in a manner consistent with our core values and our Code of Conduct.

What are the consequences for violating our Code of Conduct?

We are expected to always comply with our Code of Conduct. This Code of Conduct will be enforced, and any violation may result in disciplinary action, up to and including termination. However, consideration may be given to those who self-report. We will not tolerate retaliation of any kind against any employee who, in good faith, makes a report or cooperates in an investigation.

How do we handle ethical dilemmas?

Ethical questions are not always clear cut. They present us with difficult choices. When faced with a difficult situation, think through the issue and reference available resources.
Acting with fairness, integrity, honesty, and trustworthiness requires us to make ethical decisions. While the guidelines set out in this Code help us address specific situations.

In any ethical dilemma, ask these questions:

- Is the proposed action legal?
- Is it consistent with our core values?
- Does it comply with our Code and policies?
- Would you think it was okay if you read about it in the news?

If the answer to any of these questions is no, do not do it!

If you are still unsure about the best course of action in a particular situation, seek advice from the Compliance Team before proceeding by reaching out to any of the contacts listed in this Code of Conduct.

How should we seek guidance and report violations or concerns?

One of our most important responsibilities as part of CareOregon is to speak up if we suspect misconduct. If we know of or suspect a violation of laws, rules, regulations or this Code of Conduct we must report our concern. We have an obligation to do so.

We can ask questions or report suspected misconduct in several ways:

Discuss the question or concern with your immediate supervisor or the next level of management. This may be the most direct way to seek guidance. You can also contact Human Resources for questions about employment, benefits, employee relations and workplace issues, or Audit and Compliance for matters related to compliance and auditing.

Contact the Compliance Team for ethics questions or concerns, including violations of laws, rules, regulations, the Code of Conduct, or CareOregon's Ethics Policies. Use the EthicsPoint Hotline for reporting concerns or violations confidentially, including accounting, internal controls, and auditing matters. If you contact the EthicsPoint Hotline, you may choose to report your concerns anonymously.

COMPLIANCE & ETHICS CONTACTS

- Compliance Team complianceteam@careoregon.org
- Vice President of Audit & Compliance, Chris Zorn at zornc@careoregon.org
- EthicsPoint EthicsPoint - CareOregon, Inc. or 1-888-331-6524

What happens when a violation is reported?

CareOregon investigates reports of suspected violations confidentially, to the extent possible. You should not conduct your own investigation as doing so may compromise an investigation and could adversely affect CareOregon.

What if there is a concern of retaliation?

CareOregon policy prohibits retaliation and intimidation against someone for raising a concern about compliance. Any employee who, in good faith, seeks advice, raises a concern, reports misconduct, or cooperates in an investigation is following CareOregon policy and doing the right thing. If you feel that retaliation or intimidation has occurred, contact the Vice President of Audit and Compliance immediately. Any person who retaliates against someone for raising a compliance issue is subject to disciplinary action, up to and including termination. CareOregon gives you the opportunity to have your questions and concerns fairly considered. However, it is a violation of our Code of Conduct to knowingly submit a report or complaint with a false accusation.

OUR GUIDELINES

The Guidelines in this Code of Conduct are organized under five main categories – Responsibility for Our Workplace Environment, Responsibility for Ethical Business Practices, Responsible Use of Corporate Assets, Responsibility to Our Members and Patients, and Responsibility to Ourselves – which are intended to help us make decisions that reflect our core values and commitment to the highest standards of business ethics.

Because our employees, members, and patients all rely on us to maintain an excellent reputation, the guidelines in this Code of Conduct go beyond the minimum requirements of the law.

RESPONSIBILITY FOR OUR WORKPLACE ENVIRONMENT

We are a diverse company doing business with a diverse population. As such, we value the different backgrounds and experiences brought to CareOregon. We foster an inclusive environment where we encourage, and promote forums for, employees to engage in dialogue with one another. We continuously seek to better understand each other, and we treat each other with respect and dignity, in a manner consistent with CareOregon's principles and values.

We recognize and avoid behaviors that others may find offensive. Harassment of others, whether verbal, physical, or sexual, is prohibited in the workplace. CareOregon does not tolerate conduct that involves harassment of an employee. Any employee who creates a hostile work environment is subject to disciplinary action up to and including immediate dismissal. If you witness harassment in the workplace, contact the Compliance Team immediately through one of the methods listed above.

CareOregon promotes a Safe, Secure, and Healthy Workplace

We are committed to providing a safe, secure, and healthy environment to our employees. Activity that compromises the safety, security, or health of our employees must be reported. Acts or threats of violence compromise this commitment and will not be tolerated. Each of us plays an important role in preventing and identifying threats and situations where violence may occur. We must report any such event immediately.

We Support Human Rights

We are committed to treating each other with respect and dignity and in accordance with fair labor principles. We condemn discrimination based on race, color, sex, gender, gender identity, sexual orientation, religion, disability, national origin, veteran status, marital status, age or any other status or category that is protected by applicable state, local or federal law.

CareOregon policy prohibits retaliation and intimidation against someone for raising a compliance issue and for good faith participation in the compliance program. If retaliation or intimidation occurs, immediately inform the Vice President of Audit & Compliance. Any person who retaliates against

someone for raising a compliance issue is subject to disciplinary action. In addition, any employee who deliberately makes a false accusation with the purpose of harming or retaliating against another coworker is subject to disciplinary action.

RESPONSIBILITY FOR ETHICAL BUSINESS PRACTICES

We Comply with the Law

We comply with all applicable laws and regulations in our business. CareOregon is a nonprofit that works to elevate the wellbeing of all Oregonians, especially those living in poverty, by providing first-class healthcare and supporting efforts to improve the social conditions that affect wellness. As part of this work, CareOregon operates two of Oregon's coordinated care organizations: Jackson Care Connect, Columbia Pacific CCO, and partners in the operation of Health Share of Oregon. This means that CareOregon must follow the laws and regulations that govern the Oregon Health Plan (Medicaid). Additionally, CareOregon operates CareOregon Advantage (Medicare) and must also follow regulatory guidelines from the Centers for Medicare and Medicaid Services (CMS).

You need to be aware of the rules and regulations that impact your work. These include federal and state guidelines, such as:

- **The Health Insurance Portability and Accountability Act (HIPAA)** – requirements for how personally identifiable data should be protected from fraud and theft, including how and when protected health information (PHI) can be disclosed without a member, patient, or their authorized representative's consent.

- **Anti-Kickback Statute (AKS)** – prohibits providing or solicitating money or gifts (kickbacks) in exchange for referrals of services covered by any federal healthcare program. Violation of this law is a felony.

- **The False Claims Act (FCA)** – also called the "Lincoln Law" imposes liability on federal contractors who defraud government programs (like Medicare) by improperly receiving payment from (or withholding payment to) the Federal government. Oregon's False Claims Act is similar to the federal FCA and prohibits the submission of false or fraudulent claims to any public agency, including Oregon Medicaid.

- **Stark Law** – prohibits the referral of a Medicare or Medicaid patient to an entity (provider, laboratory, hospital) with whom the physician or an immediate family member has a financial relationship.

Additional rules and regulations may apply to the work that you do. You should familiarize yourself with your department's policies and procedures, and check with your supervisor or manager about any other requirements you need to follow. If you are unsure, reach out to Compliance for guidance.

We Prevent Fraud, Waste, and Abuse

CareOregon is committed to preventing, detecting, and correcting fraud, waste, and abuse (FWA) related to health care benefits. We are responsible for reporting any suspected health care fraud or concerns of non-compliance to any of the following resources: your supervisor, a manager or director of the company, or the Internal Audit & Compliance Department. If you report an issue to your supervisor or manager, they are required to report it to Audit & Compliance.

Annually, we complete Fraud, Waste, and Abuse training. This is required by law, but also serves to ensure that we are familiar with what these terms mean and how they impact our ability to provide healthcare to our members. CareOregon collaborates with all government agencies, including the Medicare Drug Integrity Contractor (MEDIC) to perform specific program integrity functions for the Medicare Part D Program. We maintain a comprehensive plan to detect and prevent fraud, waste, and abuse. If we have information on potential violations of Federal and/or State criminal, civil, and administrative laws, rules, and regulations we refer this information to the VP of Audit & Compliance, who will refer, as appropriate, to the MEDIC or other agency for further investigation.

We Do Not Engage in Corruption or Bribery

Never make or receive payments for the purpose of influencing anyone to do something wrong. Payments made by us, or on our behalf, must be made for lawful and legitimate business purposes. We prohibit bribery and must never pay, offer, accept, or request anything of value to secure an improper advantage.

We use Good Judgement when Exchanging Business Courtesies

CareOregon's policy is simple. We do not exchange gifts that look like an attempt to influence a business decision. No matter if you are the giver or the recipient, you need to recognize when an offer is excessive under our policy. Just say "no." Decline gifts of any value from current or potential vendors, customers, or other business partners if it would create an actual or potential conflict of interest. And never request gifts, meals, entertainment or favors from these third parties – doing so is a violation of our Code of Conduct.

Employees and vendors must take particular care when they are offered gifts, meals, entertainment, or any gratuities from potential business partners during negotiation of a transaction. Decisions involving vendors, business associates, First Tier, Downstream or Related Entities (FDR), and participating providers must be based only on the value of their goods or services for CareOregon and our members.

> *Q: Jim is in charge of choosing a new vendor to print our member ID cards. One of the vendors he is considering offers him free tickets to a Portland Pickles game. Can Jim accept the tickets?*
>
> *A: No. Jim cannot accept these tickets because they could be an attempt to influence Jim's decision. There are Federal and State regulations that prohibit CareOregon employees from*

accepting gifts like this. When in doubt, just say "No!"

Federal and State anti-kickback laws prohibit CareOregon Employees, members of the Board of Directors, and subcontractors from knowingly and willfully offering, paying, asking, or receiving any cash or other payment (such as a discount or an item of value), in return for referrals, arrangements, or orders for any good or service that could be reimbursed by public health care programs. This is a complicated area that includes many exceptions, contact the VP of Audit & Compliance if you have questions about whether this law may apply to a particular activity. Violations of the law carry serious penalties, including imprisonment.

We Ethically Handle Conflicts of Interest

Actual or potential conflicts of interest should be disclosed as soon as possible so that appropriate arrangements may be made to clearly mitigate the conflict of interest to not violate this Code of Conduct. Disclosure may be made to the Compliance Team, Human Resources, Legal Affairs, or the Procurement Department as applicable.

Q: Pam has a cousin who is looking for a job. Pam has an opening on her team, so she tells her cousin to apply for the job and she'll hire them. Did Pam do the right thing?

A: No! Pam has a conflict of interest in this situation. Her personal relationship is influencing her decisions on behalf of CareOregon.

We are all expected to act in the best interest of CareOregon. This means we must never allow our personal interests to influence our actions on behalf of CareOregon. Every decision we make while on the job must be objective and with CareOregon's business interests in mind. We value the relationships we have built with our members, providers, and other business partners. It is important that these relationships remain positive and ethical.

We Avoid Unethical Business Opportunities

We avoid taking business opportunities that arise using corporate property, information, or position; and we refrain from using CareOregon property, information, or position for personal gain or to compete with CareOregon. We will not ask for or accept an employment offer or promise of future employment based on business decisions made on behalf of CareOregon.

We conduct ourselves with impartiality and objectivity in our relationships with vendors and other business partners. We do not let our personal relationships with business partners impact our business decisions, and do not show preference based on those relationships. We do not endorse goods or services offered by our business partners unless our Legal department has approved that endorsement. We may make these endorsements as individuals, but not on behalf of CareOregon or in our professional capacity.

We Compete Fairly

CareOregon encourages collaborative relationships with other health care organizations that benefit our members and our business, but we will not participate in price fixing, bid rigging, boycotting, collusion, or any conduct creating an agreement with a competitor in violation of Federal or State antitrust laws. Generally, the laws prohibit conspiracies between competitors, improper attempts to monopolize markets or control prices, and certain unfair business practices.

We are Ethical in our Interactions with Government Agencies

We are committed to dealing honestly and fairly with government authorities and regulatory agencies. This includes complying with state and federal laws and cooperating with any valid government requests or process.

We do not make false reports. We make every reasonable effort to report accurate information (such as encounter data, financial statements, or Medicare bid information) to government agencies. If we learn that information provided was inaccurate, we contact our supervisors or the Compliance Team to determine how to correct the mistake. Knowingly making a false statement (whether verbal or written) is prohibited and could result in termination.

We fully cooperate with government investigations. If you receive a request from a government agency regarding an investigation, contact the Vice President of Audit & Compliance or the Chief Operating Officer immediately. Never attempt to obstruct an investigation or audit by lying or trying to mislead an investigator, and never destroy or alter documents requested by an investigator. Under all circumstances, we must tell the truth to government investigators or auditors.

CareOregon does not provide government officials with bribes (including gifts and entertainment) to influence their decision making. No payment or anything of value may be offered to a State or Federal government official or employee.

We Participate in the CareOregon Compliance Program

Compliance and Internal Audit periodically perform audits or reviews to ensure that operations follow Federal and State laws and regulations and, ensure processes are working the way they should be. This may include claims reviews, audits of financial transactions, analysis of billing patterns, or reviews of departmental policies and procedures.

The CareOregon Compliance Program exists to provide assurance that Federal and State laws and regulations are being followed, and that the work done at CareOregon is ethical and above-board. To be effective, a Compliance Program needs to have three lines of defense, and the first line of defense is our understanding of our responsibilities in the work that we do.

CareOregon requires that we understand our job responsibilities and the rules and regulations we must

follow, while diligently working to follow these rules and regulations. As the first line of defense, if we see something going wrong, it is our responsibility to report it to our supervisor, manager, or to the Compliance Team. As mentioned above, CareOregon is a non-retaliation workplace, so if you raise a concern and feel that you are being retaliated against you should know that you are protected under the law. The Vice President of Audit and Compliance should be made aware of any retaliation.
The CareOregon Compliance team serves as our second line of defense. When potential compliance issues arise, Compliance collaborates with operational partners to determine whether there is non-compliance. If non-compliance is substantiated, Compliance works with operational partners to ensure we strengthen the controls for the long-term. Together, operations and compliance create the necessary environment to keep CareOregon on track. Compliance is committed to being your partner.

Internal Audit serves as the third line of defense in our efforts to ensure that there are adequate controls in place to manage the risks that CareOregon encounters in our business. These risks may be financial, operational, or compliance related. Internal Audit provides an objective and independent perspective on how well we have managed our risks.

It is your responsibility to take part in the Compliance Program, by making sure that your day-to-day work is being done in compliance with regulatory requirements, and by cooperating with the Compliance and Internal Audit teams.

We Report any Concerns to Compliance

How you raise the issue is less important than making sure you raise it. There are several ways to contact your Compliance Department, there are multiple reporting avenues for internal employees to use via the intranet. You can submit a concern via email to ComplianceTeam@careoregon.org.

If you want to report a concern without giving your name, use the EthicsPoint Corporate Compliance Hotline Call Center at 1-888-331-6524 or file a report on the EthicsPoint Corporate Compliance Website, EthicsPoint - CareOregon, Inc. and include information on the incident. Reporting a compliance violation or Fraud, Waste, and Abuse concern is a condition of your employment at CareOregon. Failure to report a potential compliance violation or FWA concern could result in disciplinary action, up to and including termination of employment.

If a compliance issue is found, CareOregon takes corrective action to resolve the problem. All employees are expected to cooperate with investigation efforts. If the violation involves a subcontractor, CareOregon will take appropriate action under the contract.

RESPONSIBLE USE OF CORPORATE ASSETS

We Maintain Accurate, True, and Complete Business Records

We create and maintain business records that are accurate, true, and complete. We should never make false or misleading entries in any CareOregon accounts, financial documents, business reports or other

business documents. We should also avoid omitting any information if doing so could be misleading. We should always ensure that information within our control is properly recorded, and fully, fairly, and accurately communicated to CareOregon personnel in a timely fashion. CareOregon must provide full, fair, accurate and timely disclosures in the reports, documents and other public communications that we file with or provide to relevant regulatory bodies, including the Centers for Medicaid and Medicare Services and the Oregon Health Authority.

CareOregon expects that records will be maintained in accordance with current regulations and the established company record retention policy. Altering records or intentionally creating false records is prohibited. In addition, confidential records, such as those containing Member information or personnel information, must be secured in a manner to ensure their confidentiality. Such records may be used only for business reasons and in compliance with applicable law.

We Follow Intellectual Property Laws

CareOregon follows the laws regarding intellectual properties, including patents, trademarks, marketing, copyrights, and software. CareOregon expects that information technology is managed in accordance with Information Systems policies. We do not copy CareOregon computer software unless it is specifically allowed in the licensing agreement. CareOregon only allows authorized persons to have access to computer systems and software based on their job duties and consistent with license agreements. CareOregon does not allow unauthorized access to its computer system, either directly or by network or telephone. Employees must never perform actions that could destroy or corrupt electronically stored or processed data.

We Protect Trade Secrets

Trade secrets are confidential information that, if disclosed, would give a competitor an unfair advantage. Examples of trade secrets are non-public documents such as strategic plans, development proposals, marketing strategies, and financial information. CareOregon's policy is that trade secrets may not be disclosed unless permitted by the Chief Executive Officer in consultation with legal counsel.

We Use CareOregon Property Appropriately

The personal use of CareOregon property – including supplies, equipment, and information – is prohibited unless approved by a supervisor. Reasonable, occasional, and brief use of telephones (except long-distance calls), e-mail, and the Internet for personal reasons is permitted if that use is consistent with company policy. Check with your supervisor about appropriate use for your job. CareOregon expects that any inventoried equipment or medical supplies will be used responsibly and properly, and in line with CareOregon policies and procedures.

RESPONSIBILITY TO OUR MEMBERS AND PATIENTS

We are all expected to act in the best interest of CareOregon and our members. This means we must

never allow our personal interests to influence our actions on behalf of CareOregon. Every decision we make while on the job must be objective and with CareOregon and our member's best interests in mind. We value the relationships we have built with our members, suppliers, and other business partners. It is important that these relationships remain positive and ethical. This means:

We Protect our Members' Privacy

CareOregon is committed to preserving our members' privacy by protecting Protected Health Information (PHI) and following all laws and regulations related to privacy and the confidentiality of health information. This means following the requirements of the Health Insurance Portability and Accountability Act and other Federal and State laws. You have a responsibility and a duty to know and understand these laws and regulations and take every reasonable precaution you can to keep this information private. See the CareOregon Privacy Policy for more information.

We Treat our Members and Patients with Respect

CareOregon is committed to treating our members and patients with respect and dignity. This means providing our members with the kind of care that we would want, without judgement, discrimination, or dismissal of concerns or questions. CareOregon will not deny or place conditions on enrollment based on a person's health status. CareOregon does not target sicker enrollees or encourage them to disenroll from any of CareOregon's products for any reason. CareOregon will make meaningful efforts to recognize cultural differences among members and potential members. CareOregon is committed to following all Federal and State laws and regulations regarding conduct, as outlined by the Centers for Medicare and Medicaid Services, the Department of Health and Human Services, the Oregon Health Authority, and other regulatory entities.

We Provide Our Members and Patients with Quality Care

Quality applies to more than just medical care. Quality means doing our work with integrity, to the highest standards. Quality impacts our members through excellent customer service, prompt and accurate claims payments, reduced pain points, honest communication, and responsible stewardship of our resources. If your work for CareOregon includes direct member or patient care, CareOregon expects you to provide this care at the highest level possible.

RESPONSIBILITY TO YOURSELF

A violation of the standards described in this Code of Conduct or any CareOregon policy can result in disciplinary action, up to and including dismissal from employment or termination of your contract. Disciplinary action taken by CareOregon to uphold our Code of Conduct will be imposed consistently across the organization and in a fair and equitable manner. CareOregon has other policies and processes governing performance, conduct and behavior. Policy violations that are not Code of Conduct violations will be managed under the appropriate policy or procedure.

We are Clear about Personal Opinions and Politics

CareOregon expects that you will not present opinions or make political statements on behalf of CareOregon online, as your personal and business personas are likely to overlap. When using social media (including personal social media accounts) you must not give the appearance that you are speaking on behalf of CareOregon. If you come across posts that are negative to CareOregon, you will not directly respond.

We Support Employee Rights

While we expect you to follow our Code of Conduct, we also recognize your rights as a CareOregon Employee. For example, you have the right to speak publicly about matters of public concern or to participate in certain activities related to the terms and conditions of your employment (including discussions about wages, hours, working conditions, health hazards and safety issues). Nothing in this Code of Conduct or in any company policy is intended to limit or interfere with your rights under the law.

This Code of Conduct is a statement of the fundamental principles that govern the conduct of CareOregon's business. It does not constitute an employment contract or an assurance of continued employment. It is not intended to and does not create any obligations to or rights in any employee, client, vendor, competitor, shareholder or any other person or entity.

We Report Concerns to Compliance

If you feel that something is happening that is unethical or out of Compliance, it is your duty to say something. You can bring the issue up to your supervisor or manager, or report the issue directly to the Compliance Team at ComplianceTeam@careoregon.org or to the Vice President of Audit & Compliance, Chris Zorn, at zornc@careoregon.org. If you are not comfortable with those options, you can anonymously report the issue via Ethics Point at EthicsPoint - CareOregon, Inc. or 1-888-331-6524. EthicsPoint is anonymous, and your identity will be protected as permitted by law.

RESOURCES

TOPIC	LINK
Conflicts of Interest	Conflict of Interest Policy v.1 (policytech.com)
Information Security (Acceptable Use)	Acceptable Use Policy v.2 (policytech.com)
Procurement	Procurement and Contract Policy v.1 (policytech.com)
Business Expenses	HR Policy #414
Privacy Policy	Privacy Policy HIPAA v.1 (policytech.com)
Human Resources Policy Manual	Located in UKG
Information Security	Information Security Program Policy v.1 (policytech.com)
Trade Secrets	Confidentiality of Business Information Policy v.1 (policytech.com)
Non-Discrimination/Safe Workspace	HR Policy #104: Harassment and Discrimination
Procurement and Contracting Ethics	TBD

Title: OIG and SAM Exclusion Screening		Version: 4	Ref #: 236
Owner: Christian Zorn (Vice President, Audit and Compliance)			
Approved by ELT/CEO: 03/27/2025	Effective Date: 01/24/2014	Next Review: 03/27/2026	
Applies to *(check all that apply)*: ☐ *Medicare* ☐ *Medicaid* ☐ *Housecall Providers* ☒ *CareOregon Corporate*			

Scope

This Policy is applicable to all CareOregon Employees and all CareOregon subsidiary or affiliated entities including but not limited to Health Plan of CareOregon, Inc., Columbia Pacific CCO, LLC, Jackson County CCO, LLC, Housecall Providers Services, LLC, Housecall Providers, PC, and Care Access, LLC.

Purpose

To describe the process for ensuring that all CareOregon lines of business, including affiliated Coordinated Care Organizations (CCOs) do not employ or contract with any Individual or Entity who/that has been excluded from: (1) Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the United States, and/or (2) Federal procurement and non-procurement programs.

Definitions

Corrective Action	Corrective action minimally requires the immediate written notification to the Employee, Vendor, or Healthcare Services Contractor that an Employee or Entity appears to be an Excluded Party. If a CareOregon Employee, Human Resources will take prompt action in accordance with Human Resources policies and procedures. If a Vendor or Healthcare Services Contractor, the Excluded Party status should be confirmed and if the Vendor or Healthcare Services Contractor are an Excluded Entity, services must be immediately stopped and the contract terminated. If an employee or subcontractor of the Vendor or Healthcare Services Contractor, the employee or subcontractor must be promptly removed from providing services under the contract.
Entity	Means a prime contractor, organization, sole proprietor, corporation, partnership or any other type of entity to provide goods and/or services to CareOregon or in which CareOregon may pay or grant funds. For the purposes of this Policy, an Entity is categorized as either a Vendor or Provider.
Excluded Party	An Excluded Party is an Individual or Entity that has been suspended or debarred from doing business with federal funds and is listed on the databases maintained by the OIG and SAM. Excluded Party also includes an Individual or Entity that CareOregon knows or has reason to know that an Employee, Vendor, or Provider has been convicted of a felony or misdemeanor related to

	a crime, or violation of federal or state laws under Medicare, Medicaid, or Title XIX (including a plea of "nolo contendere".[1][2][3]
Healthcare Services Contractor	An Entity that provides direct member healthcare services or other related direct members services.
Individual or Employee	For purposes of this Policy an Individual means an employee of CareOregon which is broadly inclusive of the following: all full time and part time employees, all temporary employees, all casual employees, volunteers, CCO board members, and all interns (paid or unpaid). An Individual does not include employees from a Vendor (such as a temporary staffing employee) or a sole proprietor, all of which are considered Vendors.
OIG/SAM Exclusion Lists	Means the Exclusions Databased maintained by the Office of Inspector General ("OIG") and the System for Award Management ("SAM") maintained by the U.S. Government.
Vendor	An Entity that provides goods and/or services to CareOregon or to another entity on behalf of CareOregon. This definition is intended to be broad to include any Entity that CareOregon pays money to (e.g. grants, payments to community based organizations, donations, etc.).

Policy

Prior to hiring an Employee or entering into any kind contractual agreement with a Vendor or Healthcare Services Contractor, CareOregon shall verify that the Employee, Vendor, or Healthcare Services Contractor is not an Excluded Party and therefore ineligible to work for or contract with CareOregon. Verification that an Employee, Vendor, or Healthcare Services Contractor is not an Excluded Party is facilitated through the following departments:

- Employees - Human Resources
- Vendors – Legal Affairs and Procurement & Contract Services
- Healthcare Services Contractor – Provider Contracting and Value Based Contracting

Each of the above departments are responsible for developing and maintaining procedures to conduct exclusions checks and to maintain documentation of verification. In the event any CareOregon Employee becomes aware that an Employee, Vendor, or Healthcare Services Contractor has become excluded, they are responsible for providing immediate notification to the above respective department. The respective department will be responsible for taking appropriate Corrective Action.

In the event any other department outside the above identified departments enters into any kind of contractual agreement with a Vendor or Healthcare Services Contractor, they shall be responsible to conduct exclusions checks and to maintain documentation of verification and complete appropriate Corrective Action.

[1] In accordance with 42 USC 1320a-7, 42 CFR 1001.101 and 42 CFR 455.3

[2] CCO Contract Exhibit B, Part 9 (17)(a) & Exhibit D (9)(a)(5)

[3] Medicare Managed Care Manual, Chapter 21, 50.6.8

On a monthly basis, CareOregon shall verify that Employees, Vendors and Healthcare Services Contractors are not an Excluded Party. The below departments, in coordination with the Information System Department, are responsible for developing a procedure to conduct a monthly check to ensure Employees, Vendors, and Healthcare Services Contractors are not excluded:

- Employees – Human Resources
- Vendors – Accounts Payable
- Healthcare Services Contractor – Claims Department

If one of the respective departments above determines that an Employee, Vendor, or Healthcare Services Contractor is excluded, they will be responsible for taking appropriate Corrective Action or in the case of Accounts Payable, notifying Legal Affairs or Procurement and Contract Services for those departments to take the necessary Corrective Action.

- Should any Provider be identified as excluded during the credentialing process, OHA and OIG will be notified immediately via administrative notice sent to OHA's Provider Enrollment Unit.

Ownership/Responsibilities

Chief EDI Officer, VP of Value Based Contracting, VP and General Counsel, VP and Controller	Responsible for enforcing this Policy by establishing department processes and procedures and ensuring department staff are trained and maintain supporting documentation.
VP of Audit and Compliance	Provide company training and periodic testing to ensure compliance with the Policy.

Policies

Procurement and Contract Policy
Code of Conduct
Initial Credentialing- Credentialing
Adverse Actions- Credentialing

Title: Federal and State False Claims, Anti-kickback, and Stark Law Compliance		Version: 6	Ref #: 255
Owner: Christian Zorn (Vice President, Audit and Compliance)			
Approved by ELT/CEO: 03/03/2025	Effective Date: 01/01/2007	Next Review: 03/03/2026	
Applies to *(check all that apply)*: ☒ *Medicare* ☒ *Medicaid* ☒ *Housecall Providers* ☒ *CareOregon Corporate*			

PURPOSE

Ensure compliance with The Anti-kickback Statute[1], the Stark Law[2], the Federal False Claims Act (FCA)[3], including changes to FCA made by the Fraud Enforcement and Recovery Act of 2009, and related State of Oregon statutes[4]. It is the policy of CareOregon to consistently and fully comply with all laws and regulations pertaining to the delivery of and billing for services which apply to the organization from its participation in Medicare and Medicaid programs.

POLICY

CareOregon, its subsidiaries and affiliates (including, but not limited to; CareOregon Advantage, CareOregon Dental, Columbia Pacific CCO, Jackson Care Connect and Housecall Providers), collectively, "CareOregon" are committed to compliance with the Federal False Claims Act, the Anti-Kickback Statute, the Stark Law and associated State of Oregon laws, and promotion of policies and procedures to prevent, detect and report incidents of Fraud, Waste and Abuse (FWA). CareOregon provides Compliance and FWA training to our employees, members of the Board of Directors, subcontractors, business associates, First-tier, Downstream, and Related entities (FDRs) and participating providers to provide guidance and address remedies available under these laws and whistleblower protections available to anyone who alleges a violation of these laws.

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[1] Anti-Kickback Statute 42 U.S.C. § 1320a-7b(b)

[2] Stark law 42 U.S.C. § 1395nn

[3] Federal False Claims Act: Deficit Reduction Act, sec. 6032; 31 USC sec. 3729 – 3733; 31 USC Chapter 38; 42 USC 1320 a – 7b; 42 USC 1396a (a); Section 1902(a)(68) of the Social Security Act and Fraud Enforcement and Recovery Act, May 20, 2009.

[4] Oregon Revised Statutes:
ORS 411.670 – 411.690: Prohibition of submitting a wrongful claim or payment, the liability of the person wrongfully receiving the payment, and the amount of recovery.
ORS 646.505 – 646.656: Unlawful trade practices.
ORS chapters 162: Crimes related to perjury, false swearing and unsworn falsification.
ORS chapter 164: Crimes related to theft.
ORS chapter 165: Crimes involving fraud or deception, including but not limited to ORS 165.080 (falsification of business records) and ORS 165.690 to 165.698 (false claims for health care payments).
ORS 166.715 to 166.735: Racketeering—civil or criminal.
ORS 659A.200 to 659A.224 and ORS 659A.230 to 659A.233: Whistleblowing.
ORS 410-120-1395 to 410-120-1510: Program integrity, sanctions, fraud and abuse; common law claims founded in fraud, including fraud, money paid by mistake and money paid by false pretenses.

DEFINITION(S)

Fraud

Knowingly and willfully executing, or attempting to execute, a scheme or ploy to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Waste

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

Abuse

Actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program; improper payment; payment for services that fail to meet professionally recognized standards of care; or services that are medically unnecessary.[5]

Statute of Limitations

The time limit for bringing an action before a court or administrative agency.

Qui Tam Action

An action for violation of the False Claims Act that an individual files on behalf of the government. Qui tam is a unique mechanism in the law that allows citizens with evidence of fraud against government contracts and programs to sue on behalf of the government. As compensation for the risk and efforts, the citizen whistleblower may be awarded up to 30% of the funds recovered.

Whistleblower

An individual who brings an action for violation of the False Claims Act in the name of the government.

"Knowingly"

Actual knowledge that the information on the claims is false; acting in deliberate ignorance of whether the claim is true or false; or acting in reckless disregard of whether the claim is true or false.

Employee

For purposes of applying policies and procedures, an employee includes the following: all full time and part time employees, all temporary employees, all casual employees, volunteers, and all interns (paid or unpaid).

[5] Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines

Anti-Kickback Statute

The Anti-Kickback Statute is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies.

Criminal penalties and administrative sanctions for violating the Anti-Kickback Statute include fines, jail terms, and exclusion from participation in the Federal health care programs. Under the Civil Monetary Penalties Law, physicians who pay or accept kickbacks also face penalties of up to $50,000 per kickback plus three times the amount of the remuneration.

Stark Law

The Stark law prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements.

"Designated health services" are:

- clinical laboratory services;
- physical therapy, occupational therapy, and outpatient speech-language pathology services;
- radiology and certain other imaging services;
- radiation therapy services and supplies;
- DME 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.

The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in the Federal health care programs.

Federal False Claims Act (also known as "The Whistleblower Law") (31 U.S.C. 3729-3733):

The False Claims Act ("FCA") is a Federal statute that imposes civil penalties (between $5,000 and $10,000 plus treble damages per each false claim) on any person or entity who:

- Knowingly presents, or causes to be presented, a false claim for reimbursement by a Federal health care program, including Medicare or Medicaid;
- Makes, uses or causes to be made or used a false record or statement material to a false or fraudulent claim;
- Repays less than what is owed to the government;
- Makes, uses or causes to be made or used, a false record or statement material to reducing or avoiding repayment to the Government; and/or
- Conspires to defraud the Federal government through one of the actions listed above.

The FCA is not limited to false health care claims, but also includes any false statements or records that are material to the claim. The law applies to programs funded in whole or in part with federal funds, including Medicare and Medicaid. No specific intent is required to prove "knowledge" under the FCA. An individual or entity may be liable if the party submitting the claim had knowledge of the information and acted in deliberate ignorance or reckless disregard of the truth and falsity of the information - that is, doesn't read or review available provider guides, or hires others to do the billing without performing any oversight or monitoring on billing practices.

Some examples of a false claim:

- billing for services not rendered or goods not provided;
- denying or limiting access to services/benefits;
- under or over-utilization;
- falsifying certificates of medical necessity;
- billing for services not medically necessary;
- misrepresentation of medical condition;
- failure to report third party liability;
- eligibility determination issues;
- misrepresentation of services/supplies;
- falsifying treatment plans or medical records to maximize payments;
- failing to report overpayment or credit balances;
- duplicate billing;
- fraudulent enrollment or recoupment practices, or
- violation of another law such as submitting a claim appropriately where the service was the result of an illegal relationship between a physician and a hospital in that the physician received a kickback from a hospital for patient referrals (in violation of the Anti-Kickback law).

Remedies

A Federal false claims action may be brought by the U.S. Department of Justice Civil Division, the United States Attorney, or an individual(s) pursuant to a qui tam action. CareOregon encourages employees, members of the Board of Directors, subcontractors, business associates, FDRs, and participating providers to report false claims allegations to their supervisor, manager, director, or the Vice President (VP) of Audit and Compliance before filing a qui tam action (whistleblower).

Statute of Limitations

Under the False Claims Act, the statute of limitations is six years from the date of violation or three years after the date when material facts are known or should have been known by the government, but no later than ten years after the date on which the violation occurred.

Bringing an Action under the False Claims Act:

A private person can bring an action under the FCA in the name of the United States:

- Any person may bring an action for violation of the FCA in the name of the government. The whistleblower must be the original source of the notice to the government of the fraud with direct and independent knowledge of the information on which the allegations are based and must have voluntarily provided the information to the government before filing the action. The action cannot be based on information which is the subject of a civil suit or an administrative action to which the government is already a part and cannot be based on information which has been publicly disclosed.
- The person can file a complaint "Under Seal" or confidentiality on the court docket. "Under Seal" means that the records are kept secret on the docket of the court.
- The U.S. Attorney has sixty days, or more if an extension is requested of the court, to review the complaint and consider the allegations and whether the United States, through the Department of Justice (DOJ) will join in and take over the complaint.
- The DOJ then investigates the allegations of violations of the FCA and may involve the Federal Bureau of Investigations (FBI) or the Office of the Inspector General (OIG) of the Department of Health & Human Services and may issue subpoenas for documents or electronic records, may interview witnesses, and may compel testimony from certain individuals within CareOregon.
- After the investigation is complete, the DOJ decides whether it will intervene in the action filed by the employee, decline to intervene, or dismiss the complaint.

Whistleblower Protection

The FCA contains language protecting whistleblower employees, management, members of the Board of Directors, business associates, and FDRs from retaliation by their employer. Any employee, manager, member of the Board of Directors, business associate, or FDR who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated

against in the terms and conditions of employment by their employer because of lawful acts performed by the employee, manager, member of the Board of Directors, business associate, or FDR in furtherance of filing a FCA action shall be entitled to all relief necessary to make the employee, manager, member of the Board of Directors, business associate, or FDR whole. Damages available to employees, members of the Board of Directors, subcontractors, business associates, FDRs, participating providers, and members that prove retaliation include reinstatement with the same seniority status; double back pay with interest; compensation for any special damages; attorney fees and litigation costs.

CareOregon will not retaliate against an employees, members of the Board of Directors, subcontractors, business associates, FDRs, participating providers and members because they disclosed or intends to disclose an activity, policy or practice of the organization that they reasonably believe is in violation of a law or a rule. CareOregon will not take any disciplinary or other adverse action against any employees, members of the Board of Directors, subcontractors, business associates, FDRs, participating providers, and members who in good faith brings evidence of inappropriate care or any other violation of law or rules to the attention of the proper authority. CareOregon will not discriminate or retaliate against any employees, members of the Board of Directors, subcontractors, business associates, FDRs, participating providers, and members in any manner who in good faith reported potential violations of Federal or Oregon State law. Any individual who believes that they are a victim of retaliation may file a complaint with the VP of Audit and Compliance or Human Resources.

CareOregon expects employees, members of the Board of Directors, subcontractors, business associates, FDRs, participating providers and members and others to report concerns regarding actual or potential non-compliance with applicable Federal and State laws and/or CareOregon's internal policies and procedures through appropriate channels.

Oregon State Law and Provisions

In addition to the Federal FCA regulations, the State of Oregon has criminal and civil laws that prohibit Medicaid fraud. It is a crime if someone knowingly submits or causes to be submitted a claim for payment to which the person submitting the claim is not entitled. An individual may not:

a) Present for payment or approval, or cause to be presented for payment or approval, a claim that the person knows is a false claim.
b) In the course of presenting a claim for payment or approval, make or use, or cause to be made or used, a record or statement that the person knows to contain, or to be based on, false or fraudulent information.
c) Agree or conspire with other persons to present for payment or approval a claim that the person knows is a false claim.
d) Deliver or cause to be delivered, property to a public agency in an amount the person knows is less than the amount for which the person receives a certificate or receipt.

e) Make or deliver a document certifying receipt of property used by a public agency, or intended to be used by a public agency, that the person knows contains false or fraudulent information.

f) Buy property of a public agency from an officer or employee of a public agency if the person knows that the officer or employee is not authorized to sell the property.

g) Receive property of a public agency from an officer or employee of the public agency as a pledge of an obligation or debt if the person knows that the officer or employee is not authorized to pledge the property.

h) Make or use, or cause to be made or used, a false or fraudulent statement to conceal, avoid or decrease an obligation to pay or transmit moneys or property to a public agency if the person knows that the statement is false or fraudulent.

Reference: Oregon Revised Statute ORS 165.692

Employee Responsibilities

All employees, members of the Board of Directors and subcontractors are expected to follow the guidelines set forth below and to seek and abide by the advice from CareOregon's Legal Counsel or the Audit and Compliance Officer:

- CareOregon is required to submit accounting and other records to the Federal and/or State government as a basis for payment on existing contracts and estimates on future contracts. As such, no employees, temporary and contract employees, volunteers, members of the Board of Directors and subcontractors shall knowingly include within a cost proposal, costs which have been declared unallowable by statute or regulation.
- CareOregon employees, members of the Board of Directors and subcontractors are required to be familiar with Medicaid and Medicare regulations.
- Employees, members of the Board of Directors and subcontractors shall not accept, directly or indirectly, entertainment or gratuities, including meals at business meetings, where prohibited by applicable law.
- Any employee, member of the Board of Directors and subcontractor, who in good faith believes that they have knowledge of a potential violation of this policy, must report this information through normal supervisory channels, the EthicsPoint hotline or directly to the VP of Audit and Compliance.
- Any employee, member of the Board of Directors and subcontractor may also directly report any complaint of potential fraud to federal agencies such as OIG (1-800-447-8477) or MFCU (971-673-1880).
- Violations of this policy or failure to report a known violation of the policy may result in disciplinary action, up to and including termination.

An individual or entity is subject to civil damages if a previous warning has been issued about an unlawful billing practice yet continues the practice.

PROCEDURE

Responsibility	**Action**	
VP of Audit and Compliance	1. Review this policy annually. 2. Ensure educational materials and training on the False Claims Act are provided to all CareOregon employees at time of hire and annually thereafter.	
Responsibility	**IF**	**THEN**
VP of Audit and Compliance	Laws, rules, or regulations affecting this policy have changed.	Revise this policy accordingly.
	Training/educational materials are provided at time of hire or contracting.	Require the employees, members of the Board of Directors, subcontractors, business associates, FDRs, and participating providers to acknowledge that they have received Compliance and FWA Training Material at time of hire or contracting.
Responsibility	**IF**	**THEN**
Employees, members of the Board of Directors, subcontractors, business associates, FDRs, and participating providers	You see or know of billing or claims practices that appear inappropriate or look like one of the examples of a false claim.	Report it to your supervisor, manager, or director. If you are not comfortable reporting to your supervisor, manager, or director, report to Human Resources, the VP of Audit and Compliance or the Compliance Department. You can also report any issues of FWA in Medicare, Medicaid, and other HHS program directly to federal agencies such as OIG.
	Failure to participate in initial or annual FWA and Compliance Training (of which the False Claims Act is an element).	Disciplinary action up to and including termination of employment or termination of a contractual or agency status

RELATED POLICIES AND PROCEDURES

Compliance and FWA Training

OTHER RELATED DOCUMENTS

http://www.justice.gov/civil/docs_forms/C-FRAUDS_FCA_Primer.pdf

Title: Medicaid Overpayment Identification and Reporting policy		Version: 3	Ref #: 707
Owner: Lynska Villiarimo (Vice President, Claims, Payment Integrity & Enrollment Operations)			
Approved by ELT/CEO: 01/30/2023	Effective Date: 03/20/2020	Next Review: 01/30/2024	
Applies to *(check all that apply)*: ☐ *Medicare* ☒ *Medicaid* ☐ *Housecall Providers* ☐ *CareOregon Corporate*			

Scope

CareOregon is committed to identifying claims overpayments related to Medicaid claims payment to healthcare professionals.

Purpose

Community Care Organizations (CCO's) are required to have adequate controls in place to identify, report and recover overpayments under the Health Plan Services Contract with the Oregon Health Authority (OHA).

Definitions

Coordinated Care Organization (CCO)	A network of all types of health care providers (physical health care, mental health care and dental care providers) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid).
Oregon Health Authority (OHA)	A government agency in the U.S. division of the Department of Human Services (DHS) for the State of Oregon. OHA oversees Oregon's health related programs including behavioral health (addictions and mental health), public health, State hospitals and the Medicaid program.

Policy

An overpayment is any payment that exceeds amounts properly payable under Medicaid statutes and regulations.

CareOregon has provisions to self-report to OHA any Overpayment it received from OHA under the CCO contract or any other contract, agreement, or Memorandum of Understanding (MOU) entered into by CareOregon and OHA. CareOregon must report Overpayments to OHA within sixty (60) days of its identification **42 CFR §401.305**.

CareOregon must report to OHA any Overpayments made to Providers, Subcontractors, or other third parties, regardless of whether such Overpayment was made as a result of the self-reporting by a Provider, Subcontractor, other third-party, or identified by CareOregon and

regardless of whether such Overpayment was the result of a Fraud, Waste, or Abuse or accounting error.

If identification of Overpayment was the result of self-reporting to CareOregon by a Provider, Subcontractor, other third-party, such foregoing reporting provision must include the obligation to report, as required under 42 CFR §401.305, such Overpayment within sixty (60) days of the Provider's, Subcontractor's, or other third-party's identification of the Overpayment.

If Overpayments are identified by CareOregon as a result of an audit or investigation, such Overpayment must be reported to OHA promptly, but in no event more than seven (7) days after identifying such Overpayment (SIU Investigation and Reporting of suspected Fraud, Waste, and Abuse (FWA)).

CareOregon must accurately report all overpayments, identified or recovered, on its quarterly and annual Financial Reports (Exhibit L of the CCO Contract) regardless of whether the Overpayments were the result of self-reporting or the result of a routine or planned audit or other review; or a payment that exceeds amounts properly payable under Medicaid statutes and regulations.

Documenting and Processing Recovery of Overpayments

In addition to reporting all identified and recovered Overpayments made to Providers, Subcontractors, CareOregon must also comply with all the procedures for managing and otherwise processing the recovery of such Overpayments as follows:

- CareOregon must adjust, void, or replace, as appropriate, each Encounter claim to reflect the Valid Encounter claim once CareOregon has recovered Overpayment within thirty (30) days of identifying such Overpayment.
- CareOregon must maintain records of our actions and Subcontractors' actions related to the recovery of Overpayments made to Providers, Subcontractors, or other third parties. Such records maintenance must be made in accordance with and made available to OHA and other parties in accordance the CCO Contract (Ex. D, section 14).
- In the event CareOregon investigates or audits its Providers, Subcontractor, or any other third-party and Overpayments made to such parties are identified as the result of Fraud, Waste, or Abuse, CareOregon may collect and retain such Overpayments as set forth in CCO Contract (Ex. B, Part 9 section 14).
- If CareOregon or its Subcontractors conduct audits of CareOregon's Providers or Providers' Encounter Data that results in a finding of Overpayment, CareOregon must return to OHA any and all applicable federally matched funds but is permitted to keep any sums recovered in excess of the federally matched funds as calculated by OHA.

Examples of Overpayment types that might be made to Providers, Subcontractors, or other third parties include, but are not limited to, the following:

- Payments for Non-Covered Services,
- Payments in excess of the allowable amount for an identified covered service,
- Errors and non-reimbursable expenditures in cost reports,
- Duplicate payments, and
- Receipt of Medicaid payment when another payer had the primary responsibility for payment and is not included in an automated TPL retroactive recovery process.

CareOregon does not have the right, to retain any Overpayments made to any Provider or any Subcontractor that are recovered as a result of the following:

- Claims brought under the State or federal False Claims Acts;
- A judgment or settlement arising out of or related to litigation involving claims of Fraud,
- Through government investigations, such as amounts recovered by PIAU or MFCU or any other State or federal governmental entity, regardless of whether CareOregon referred the matter to such parties.

In the event OHA determines that a credible allegation of Fraud has been made against CareOregon, OHA will have the right to suspend, in whole or in part, Payments made to CareOregon. In the event OHA determines that a credible allegation of Fraud has been made against CareOregon's Subcontractors, OHA will also have the right to direct CareOregon to suspend, in whole or in part, the payment of fees to any and all such Subcontractors. Subject to **42 C.F.R. §455.23(c)** suspension of Payments or other sums may be temporary. OHA has the right to forgo suspension and continue making Payments, or refrain from directing CareOregon to suspend payment of sums to its Subcontractors, if certain good cause exceptions are met as provided for under **42 C.F.R. §455.23(e)**.

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

Ownership/Responsibilities

CUPID Committee	Approves Claims Payment Integrity policies and serves as a point of escalation
Finance	Works closely with claims to track and report on spending by service type and to identify any unusual trends in costs or utilization.
Payment Integrity Functional	Helps to facilitate accurate claim payments across CareOregon's health

Workgroup	plan systems.

Compliance Enforcement

The Payment Integrity Functional Workgroup, with representation from Operations, Medical Management, Network & Clinical Services, Provider Contracting, Provider Relations, IS, Finance, compliance, Fraud Waste Abuse and Legal Affairs, ensures that identified overpayment issues are addressed and resolved through the biweekly meetings. The workgroup may escalate options and recommendations for high-dollar recovery, overpayment, and adjustment projects to CUPID Committee or to the Escalation Team for approval.

Regulations

42 C.F.R. §438 Subpart H and 42 C.F.R. §455.23
CCO Medicaid Contract

Related

Claim Payment and Coding Compliance Review Policy

Encounter Data Validation Audits Policy