EOCCO Compliance and Fraud, Waste and Abuse Prevention Plan

March 2020

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Purpose

The Eastern Oregon Coordinated Care Organization ("EOCCO") board of directors has adopted this Ethics and Compliance Program ("Program") to articulate EOCCO's longstanding commitment to support the provision of comprehensive health services to its Oregon Health Plan Members through its Subcontractors and Providers in compliance with all federal, state and local laws and regulations; to prevent, detect and prevent fraud, waste and abuse by its workforce, Subcontractors, Providers, Members, and other third parties; and to set forth an annual fraud, waste and abuse prevention plan ("FWA Plan") for implementing, analyzing, and reporting on the effectiveness of the policies and procedures set for the in EOCCO's FWA Prevention Handbook. In addition, it supports the promotion of an organizational culture that encourages ethical conduct and places the highest value on integrity in the achievement of its mission.

This Program has been designed to address the elements identified by the Federal Sentencing Guidelines and the Office of Inspector General of the U.S. Department of Health and Human Services that are required for the implementation of an effective compliance and ethics program and EOCCO's contractual obligations under the Health Plan Services Contract ("Contract") with the Oregon Health Authority.

Program Oversight

The EOCCO 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 will act in good faith in the exercise of its oversight responsibility for its organization, including making inquiries to ensure: (1) a corporate information and reporting system exists and (2) the reporting system is adequate to assure the Board that appropriate information relating to compliance with applicable laws will come to its attention timely and as a matter of course. The existence of a corporate reporting system not only keeps the Board informed of the activities of the organization, but also enables the organization to evaluate and respond to issues of potentially illegal or otherwise inappropriate activity.

EOCCO has established a regulatory compliance committee at the board level and senior management level that includes the chief compliance officer, senior level management staff, and members of the board of directors and is responsible for the operational oversight of EOCCO's compliance program and its compliance with the Contract.

The board has appointed a chief compliance officer who reports directly to the CEO and board of directors and who is responsible for developing and implementing compliance related policies,

procedures and practices and the Annual FWA Prevention Plan. The chief compliance officer is delegated sufficient authority and adequate resources to undertake and comply with these responsibilities.

The compliance office consists of the chief compliance officer and at least one individual who reports directly to him/her.

Standards of Conduct and Policies and Procedures

EOCCO's standards of conduct, contained in the Code of Conduct (the "Code") describe the ethical principles and standards of business practice for EOCCO's workforce and Subcontractors and demonstrate compliance with applicable requirements under the Contract. Those standards describe the behavior that is expected when interacting with other members of the EOCCO workforce in the performance of one's duties and provides guidance to ensure that their work is done in an ethical and legal manner.

In addition to the Code, EOCCO has implemented policies, procedures and internal controls that ensures compliance with the requirements set forth in 42 CFR Part 455, 42 CFR Part 438, Subpart H, and OAR 410-120-1510 (Fraud Prevention Handbook) and that describe the mechanism by which management exercises due diligence in seeking not only to reduce the likelihood of misconduct, but to facilitate compliance with all applicable federal and State laws and prevent and detect any behavior contrary to those principles. The objectives of those policies and procedures, along with the Code are to: 1) provide comprehensive guidelines and standards for the provision of its services; 2) monitor the implementation of those guidelines and standards as a routine daily practice; 3) enhance a corporate culture which supports compliance with federal and state statutes and regulations, and 4) build community trust in EOCCO.

To the extent that EOCCO subcontracts to any third parties any responsibility for providing services to Members or processing and paying for claims, EOCCO will require its Subcontractors, pursuant to its subcontracts, to comply with the terms and conditions set forth in Sections 11-18 of Exhibit B, Part 9 of the Contract.

The Code and relevant policies and procedures are developed with consideration for the rich and varied backgrounds of EOCCO's workforce and will be made available to all workers. These policies and procedures will be reviewed annually and periodically updated to address new or modified statutes and/or regulations which apply to the services EOCCO provides. They will also be submitted annually to the OHA Contract Administrator and other appropriate bodies charged with responsibility for operating and monitoring the Program.

Excluded Individuals and Organizations and Prohibited Affiliations

EOCCO will not employ, contract with or have a relationship with any individual or organization who/that has been excluded from: (1) Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the United States, and (2) federal procurement and non-procurement programs. The relationships described above are as follows:

- A director, officer, or partner of EOCCO
- A subcontractor of EOCCO
- A person with beneficial ownership of 5 percent or more of EOCCO's equity
- A network provider or person with an employment, consulting or other arrangement with EOCCO for the provision of items and services that are significant and material to EOCCO's obligations under its contract with the State.

EOCCO will immediately report to the Federal Department of Health and Human Services ("DHHS"), Office of the Inspector General ("OIG"), any Providers, identified during the credentialing process, who are include on the List of Excluded Individuals ("LEIE") or on the Excluded Parties List System ("EPLS") also known as System for Award Management ("SAM"). Reporting requirements can be met by providing such information to OHA's provider Services via Administrative Notice. EOCCO will provides notification to OHA within 30 days when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement.

Effective Communication, Training and Education

Systems are in place that are designed to maintain effective lines of communication between the EOCCO compliance office and its workforce. Reasonable steps are also taken to effectively communicate, periodically and in a practical manner the Code of Conduct, policies and procedures contained in this Program to the board of directors, high-level personnel, substantial authority personnel, EOCCO workforce members, and, as appropriate, Subcontractors of EOCCO.

Communications with workers will emphasize: (1) EOCCO's commitment to ethical conduct; (2) the importance of statutory and regulatory compliance; (3) the identification of laws and regulations as they relate to an individual's job; and (4) the obligation of each worker to behave in a manner consistent with those statutes and regulations and the principles articulated in the Code.

This will be supported by conducting effective training and education for the federal and State standards and requirements under the Contract and otherwise disseminating information appropriate to such individuals' respective roles and responsibilities.

EOCCO provides and requires annual attendance at training and education for the

compliance officer, senior management, other members of the EOCCO workforce and Subcontractors regarding its fraud, waste, and abuse policies and procedures. Such training and education includes, without limitation, the right to be protected as a whistleblower for reporting any fraud, waste, or abuse as well as annual education and training to members of EOCCO's workforce who are responsible for credentialing Providers and subcontracting with third parties. Such annual education and training includes material relating: (1) the credentialing and enrollment of Providers and Subcontractors and (2) the prohibition of employing, subcontracting, or otherwise being affiliated with (or any combination or all the foregoing) sanctioned individuals.

Training will be provided in a variety of ways: in-person education, email reminders, video conferencing and other modalities.

Monitoring and Auditing

EOCCO will develop and implement an annual plan to audit Providers and Subcontractors that will enable EOCCO to validate the accuracy of encounter data against provider charts and identify fraud, waste, and abuse risks and other related compliance risks. The results of these auditing and monitoring activities will be reported periodically to the EOCCO chief executive officer and the board of directors.

EOCCO will routinely verify whether services that have been represented to have been delivered by network Providers were received. Such verification will be made by mailing service verification letters to Members, sampling, hotline reports or other methods.

Internal Reporting of Suspected Non-Compliance

EOCCO is committed to providing an environment that encourages and allows workers to report or to seek and receive prompt guidance before engaging in conduct that is believed to be inconsistent with federal or State statutes or regulations, the EOCCO ethics and compliance program or its Code of Conduct.

While EOCCO encourages members of the EOCCO workforce or Subcontractors to report suspected misconduct to their supervisor, manager or the compliance officer, EOCCO provides a toll-free hotline that allows EOCCO employees and others to report or seek guidance anonymously or confidentially regarding potential or actual non-compliance without fear of retaliation. EOCCO will maintain the privacy and anonymity of reporting parties except where legally proscribed. The ability of EOCCO to ensure total confidentiality may be limited by legal obligations relating to self-disclosure, law enforcement subpoenas, and civil discovery requests. Each report will be documented, and a response provided, if possible, to the reporter.

Responding to a Suspected Violation

When potential fraud, waste, and abuse and other related compliance problems are reported or identified in the course of self-evaluation, hotline reports and audits, the allegations will be promptly investigated. In the event that an investigation reveals misconduct, corrective action will be immediately initiated.

Prompt and thorough correction (or coordination of suspected criminal acts with law enforcement agencies) of any and all incidents of fraud, waste, and abuse and other related compliance problems will be taken in a manner that is designed to reduce the potential for recurrence, including the identification of any systemic shortcomings that compromise the deterrent effect of its Program. If necessary, appropriate modifications will be made to the Program.

External Reporting of Fraud, Waste or Abuse

Using the FWA Report Template, EOCCO will provide to OHA, via Administrative Notice, an annual summary report of referrals, and cases investigated ("Annual FWA Referrals & Investigations Report"). The annual FWA Referrals and Investigations Report will be provided to OHA promptly after January I of each contract year following the reporting year but in no event later than January 31st

EOCCO will report all suspected cases of fraud, waste, and abuse, including suspected fraud committed by its employees, Providers, Subcontractors, Members, or any other third parties to OHA's Program Integrity Audit Unit ("PIAO") and DOJ's Medicaid Fraud Control Unit ("MFCU"). Reporting shall be made promptly but in no event more than seven (7) days after EOCCO is initially made aware of the suspicious case. 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 Program Integrity Audit Unit (PIAU)
3406 Cherry Ave. NE Salem, OR
97303-4924
Fax: 503-378-2577
Hotline: 1-888-FRAUD0l (888-372-8301)

EOCCO will cooperate with the MFCU and allow them to inspect, evaluate, or audit

books, records, documents, files, accounts, and facilities as required to investigate an incident of fraud or abuse as follows:

- EOCCO will provide copies of reports or other documentation requested by MFCU, PIAU, or their respective designees, or any or all of them. All reports and documents required will be provided without cost to MFCU, PIAU, or their designees;
- EOCCO will permit MFCU, PIAU, 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 EOCCO as such parties may determine is necessary to investigate any incident of fraud, waste, or abuse;
- EOCCO will cooperate in good faith with the MFCU, PIAU, as well as their respective designees, or any or all of them, during any investigation of fraud, waste, or abuse; and
- In the event that EOCCO reports suspected fraud, waste, or abuse by EOCCO's Subcontractors, Providers, Members, or other third parties, or learns of an MFCU, or PIAU investigation, or any other fraud, waste, and abuse investigation undertaken by any other governmental entity, EOCCO is strictly prohibited from notifying, or otherwise communicating with, such parties about such report(s) or investigation(s) so as not to compromise the investigation.

If EOCCO is made aware of a credible allegation of fraud by the MFCU, or of a pending investigation against a provider, EOCCO will, upon notification of an investigation by MFCU, suspend payments to the provider unless the MFCU determines there is good cause not to suspend payments or to suspend payments in part.

EOCCO will include the above contact information for MFCU and PIAU in its FWA Prevention Handbook and its Member Handbook.

External Reporting of Overpayments

Using the FWA Report Template (found on the Contract Reports website), and in accordance with EOCCO's FWA Prevention Handbook and Annual FWA Prevention Plan, EOCCO will provide OHA with quarterly and annual reports of all audits performed ("Annual FWA Audit Report"). The Annual FWA Audit Report will include information on any provider overpayments that were recovered, the source of the provider overpayment recovery, and any sanctions or corrective actions imposed by EOCCO on its Subcontractors or Providers. The quarterly FWA Report is due thirty (30) days following the end of each quarter and will be provided to OHA via Administrative Notice.

EOCCO will self-report to OHA any overpayment it received from OHA under the Contract or any other contract, agreement, or MOU entered into by EOCCO and OHA. This includes the obligation to report, as required under 42 CFR §401.305 such overpayment to OHA within sixty (60) days of its identification.

If the overpayment was identified by Contractor as a result of an audit or investigation, it must be reported to OHA promptly, but in no event more than seven (7) days after identifying such Overpayment.

EOCCO will return the overpayment within 60 calendar days after the date on which the overpayment was identified and notify EOCCO in writing of the reason for the overpayment.

Reporting a Case of Fraud or Abuse by a Member

EOCCO, if made aware of suspected fraud or abuse by a Member (e.g. a Provider reporting Member fraud, waste and abuse) will promptly report the incident to the DHS/OHA fraud Investigation Unit. Such reporting may be made by mail, phone, or facsimile transmission using the following contact information:

DHS/OHA Fraud Investigation
PO Box 14150
Salem, OR 97309
Hotline: 1-888-FRAUD01
(1-888-372-8301)
Fax: 503-373-1525 Attn: Hotline); or

Reports may also be made via on-line portal at:

https://sharedsystems.dhsoha.state.or.us/opr_fraud_ref/index.cfm?act=evt.subm_web

EOCCO will include the above contact information for DHS/OHA fraud investigation in its FWA Prevention Handbook and its Member Handbook.

Required Network Provider Reporting

Network Providers will report an overpayment to EOCCO and to return the overpayment within 60 calendar days after the date on which the overpayment was identified, and to notify EOCCO in writing, the reason for the overpayment.

Enforcement and Disciplinary Action

Each member of the EOCCO workforce is responsible for supporting an environment that encourages ethical and compliant conduct and fosters reporting behavior inconsistent with such conduct. Disciplinary action will be initiated against: (1) individuals who have failed to comply with EOCCO's Code, compliance policies, applicable statutes, regulations or federal health care program requirements; (2) responsible individuals who unreasonably fail to detect

or report an offense; or (3) those who have otherwise engaged in wrongdoing that has the potential of impairing EOCCO's status as a reliable, honest, provider of health care services. EOCCO disciplinary guidelines are published in the Employee Handbook.

Evaluation of Program Effectiveness

In addition to creating the written FWA Prevention Handbook, the EOCCO compliance officer, with the assistance of EOCCO's compliance team, will annually draft the FWA Plan for implementing, analyzing, and reporting on the effectiveness of the policies and procedures set forth in EOCCO's ethics and compliance program. This plan will, at a minimum, include written plans and procedures for all of the following activities:

- Routine internal monitoring, reporting, and auditing of fraud, waste, and abuse risks and other related compliance risks;
- Prompt response to fraud, waste, and abuse and other related compliance issues as they are reported or otherwise discovered;
- Investigation of potential fraud, waste, and abuse and other related compliance problems as identified in the course of self-evaluation and audits;
- Prompt and thorough correction (or coordination of suspected criminal acts with law enforcement agencies) of any and all incidents of fraud, waste, and abuse and other related compliance problems in a manner that is designed to reduce the potential for recurrence;
- Activities that support on-going compliance with the fraud, waste, and abuse prevention and other compliance requirements under this Contract;
- Risk evaluation procedures to enable compliance in identified problem areas such as claims, prior authorization, service verification, utilization management and quality review; and
- The development and implementation of an annual plan to audit Providers and Subcontractors that will enable EOCCO to validate the accuracy of encounter data against provider charts.

FWA Assessment of FWA Prevention Plan Effectiveness and Report

EOCCO will submit an annual assessment report of the quality and effectiveness of its annual FWA Prevention Plan and the related policies and procedures included in its FWA Prevention Handbook ("Annual FWA Assessment Report"). The Annual FWA Assessment Report will include an introductory narrative of the foregoing efforts and effectiveness. The Annual FWA Assessment Report will include, with respect to the previous contract year, all of the following information:

- The number of preliminary investigations and the final number of referrals to PIAU or MFCU or both;
- The number of subcontractor and provider audits and the number of subcontractor and provider reviews were conducted by EOCCO and whether they were performed on-site or based on a review of documentation;

- The training and education provided to and attended by EOCCO's chief compliance officer, its employees, and, if applicable, its Providers and Subcontractors;
- Compliance and fraud, waste, and abuse prevention activities that were performed during the reporting year. Such report will include: (i) a review of the provider audit activity EOCCO performed and whether such audit activity was in accordance with EOCCO's FWA Prevention Plan, (ii) a description of the methodology used to identify high-risk Providers and services, (iii) compliance reviews of Subcontractors, Providers, and any other third parties, including a description of the data analytics relied upon, and (iv) any applicable request for technical assistance from OHA on improving the compliance activities performed by EOCCO;
- A sample of the Service Verification Letters mailed to Members, and report on: (1) the number of Service Verification letters sent, (2) how Members were selected to receive such Letters, (3) member response rates, (4) the frequency of mailings, including all dates on which such letters were mailed, (5) the results of the efforts, and (vi) other methodologies used to ensure the accuracy of data; and
- A narrative and other information that advises OHA of: (1) the outcomes of all of the fraud, waste, and abuse prevention activities undertaken by EOCCO, and (2) proposed or future process, policies, and procedure improvements to address deficiencies identified.

EOCCO's Annual FWA Assessment Report will be provided to OHA via Administrative Notice by no later than January 31 of each contract years two, three, and four. OHA will advise EOCCO of its reporting requirements for contract year five at least one-hundred and twenty (120) days prior to the contract termination date.

Compliance Risk Assessment

EOCCO will periodically assess the risk of the occurrence of fraud, waste or abuse and other misconduct to enable compliance in identified problem areas such as claims, prior authorization, service verification, utilization management and quality review. Specifically, EOCCO will evaluate the nature and seriousness of the misconduct, the likelihood that certain criminal conduct may occur because of the nature of the organization's business, and the prior history of the organization. EOCCO's compliance and ethics resources will be prioritized to target those potential activities that pose the greatest threat considering the risks identified.

Review and Approval of Fraud, Waste, and Abuse Handbooks

EOCCO will provide to OHA via Administrative Notice, its FWA Prevention Handbook and Annual FWA Prevention Plan and to OHA for review and approval by no later than January 31 of each Contract Year. EOCCO's Annual FWA Prevention Plan and the, policies and procedures set forth in the FWA Prevention Handbook will not be implemented or distributed prior to approval by OHA. Review and approval shall be provided to EOCCO, via Administrative Notice to EOCCO's Contract Administrator, by OHA within thirty (30)

days of receipt. In the event OHA disapproves of either or both the Annual FWA Prevention Plan and the FWA Prevention Handbook for failing to meet the terms and conditions of this Contract and any other applicable State and federal laws, EOCCO will, in order to remedy the deficiencies in the Annual FWA Prevention Plan and FWA Prevention Handbook, follow the process set forth in Sec. 5, Ex. D of the Contract.

EOCCO will review and update its Annual FWA Prevention Plan and FWA Prevention Handbook annually and provide, to OHA via Administrative Notice, copies of such documents for OHA's review and approval. In the event EOCCO has not made any changes to its FWA Prevention Handbook since it was last approved by OHA, EOCCO will include an attestation that no changes have been made since it was last approved. After OHA's initial approval of EOCCO's Annual FWA Prevention Plan and FWA Prevention Handbook, EOCCO will submit such Plan and Handbook for subsequent review and approval as follows:

- To OHA via Administrative Notice upon any significant revisions, regardless of whether such changes are made prior or subsequent to annual approval by OHA, or prior to EOCCO's final adoption of such Plan or Handbook after initial approval by OHA. The revised Annual FWA Prevention Plan or FWA Prevention Handbook, or both. In the event the revised Annual FWA Prevention Plan or FWA Prevention Handbook fails to meet the terms and conditions of the Contract or applicable law, EOCCO shall follow the process set forth in Sec. 5, Ex. D of the Contract.
- To OHA anytime upon OHA request. EOCCO will provide OHA with the requested Annual FWA Prevention Plan or FWA Prevention Handbook, or both, in the manner requested by OHA.

OHA and EOCCO Audits of Network Providers

If OHA conducts an audit of EOCCO's Providers or the Providers' encounter data that results in a finding of overpayment, OHA will calculate the final overpayment amount for the audited claims using the applicable fee-for-service fee schedule and recover the overpayment from EOCCO. EOCCO has the right, at its discretion, to pursue recovery of the overpayments made by EOCCO to the applicable Providers.

If OHA conducts an audit of EOCCO's Providers or the Providers' encounter data that results in an administrative or other non-financial finding, EOCCO agrees to use the information included in OHA's final audit report to rectify any identified billing issues with its Providers and pursue financial recoveries for improperly billed claims if applicable.

If EOCCO or its Subcontractors conduct an audit of EOCCO's Providers or Providers' encounter data that results in a finding of overpayment, EOCCO will return to OHA any and all applicable federally matched funds but is permitted to keep any sums recovered in excess of the federally matched funds as calculated by OHA.

Recoveries that are retained by EOCCO will be reported as set forth in Sub. Paragraph (17) Section. 11, and Sec. 15, Paragraph b. of the Contract.

Documenting and Processing EOCCO Recovery of Overpayments Made to Third Parties

EOCCO will also comply with all of the procedures for managing and otherwise processing the recovery of such overpayments as follows:

- EOCCO will adjust, void or replace, as appropriate, each encounter claim to reflect the Valid Encounter claim once EOCCO has recovered Overpayment within thirty (30) days of identifying such Overpayment.
- EOCCO will maintain records of EOCCO's actions and Subcontractors' actions related to the recovery of overpayments made to Providers, Subcontractors, or other third parties. Such records maintenance will be made in accordance with and made available to OHA and other parties in accordance with Ex. D, Sec.14 of the Contract.
- In the event EOCCO 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, EOCCO may collect and retain such overpayments.
- 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 third-party liability retroactive recovery process.

EOCCO does not have the right to retain any overpayments made to any provider or any Subcontractor that are recovered as a result of (1) claims brought under the State or federal False Claims Acts (2) a judgment or settlement arising out of or related to litigation involving claims of fraud, or (3) through government investigations, such as amounts recovered by PIAU or MFCU or any other State or federal governmental entity, regardless of whether EOCCO referred the matter to such parties.

Reporting Changes in Eligibility

EOCCO will notify OHA within 30 days when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the

EOCCO, including the termination of the provider agreement. Reporting requirements can be met by providing such information to OHA's provider Services via Administrative Notice.

EOCCCO will also promptly notify OHA when EOCCO receives information about changes in a Member's circumstances that might impact eligibility, including changes in a Member's residence, and death of a Member.

EOCCO will ensure that all network Providers are enrolled with the State of Oregon as Medicaid Providers consistent with provider disclosure, screening and enrollment requirements of part 455, subparts B and E.

Member Grievance and Appeal Resolution Processes

EOCCO has a process in place to resolve Member grievances and appeals that protect the anonymity of complaints and to protect callers from retaliation.

Federal and State Statutes and Regulations

Applicable Federal Laws

As a participant in federal Medicaid program EOCCO, its employees, agents, and contractors are required to comply with the following federal laws.

A. False Claims Act - The federal civil False Claims Act ("FCA") is one of the most effective tools used to recover amounts improperly paid due to fraud and contains provisions designed to enhance the federal government's ability to identify and recover such losses. The FCA prohibits any individual or company from knowingly submitting false or fraudulent claims, causing such claims to be submitted, making a false record or statement in order to secure payment from the federal government for such a claim, or conspiring to get such a claim allowed or paid. Under the statute the terms "knowing" and "knowingly" mean that a person (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. Examples of the types of activity prohibited by the FCA include billing for services that were not actually rendered, and upcoding (billing for a more highly reimbursed service or product than the one provided).

The FCA is enforced by the filing and prosecution of a civil complaint. Under the Act, civil actions will be brought within six years of a violation, or, if brought by the government, within three years of the date when material facts are known or should have been known to the government, but in no event more than ten years after the date on which the violation was committed. The Act allows for inflationary adjustments, and in 2019 FCA violations will result in a civil penalty per false claim, of not less than $11,181 and not more than $22,363, plus treble the government's actual damages.

Qui Tam and Protection Provisions - The False Claims Act contains *qui tam*, or whistleblower provision. Qui tam is a unique mechanism in the law that allows citizens to bring actions in the name of the United States for false or fraudulent claims submitted by individuals or companies that do business with the federal government. A *qui tam* action brought under the FCA by a private citizen commences upon the filing of a civil complaint in federal court. The government then has sixty days to investigate the allegations in the complaint and decide whether it will join the action. If the government joins the action, it takes the lead role in prosecuting the claim. However, if the government initially decides not to join, the whistleblower may pursue the action alone, with the government maintaining the ability to join the action at a later date. As compensation for the risk and effort involved when a private citizen brings a qui tam action, the FCA provides that whistleblowers who file a qui tam action may be awarded a portion of the funds recovered (typically between 15 and 25 percent) plus attorneys' fees and costs.

Whistleblowers are also offered certain protections against retaliation for bringing an action under the FCA. Employees who are discharged, demoted, harassed, or otherwise encounter discrimination as a result of initiating a qui tam action or as a consequence of whistleblowing activity are entitled to all relief necessary to make the employee whole. Such relief may include

reinstatement, double back pay with interest, and compensation for any special damages including attorneys' fees and costs of litigation.

B. Federal Program fraud Civil Remedies - The Program fraud Civil Remedies Act of 1986 provides for administrative remedies against persons who make, or cause to be made, a false claim or written statement to certain federal agencies, including the Department of Health and Human Services. Any person who makes, presents, or submits, or causes to be made, presented or submitted a claim that the person knows or has reason to know is false, fictitious, or fraudulent is subject to civil money penalties of up to $5,000 per false claim or statement and up to twice the amount claimed in lieu of damages. Penalties may be recovered through a civil action or through an administrative offset against claims that are otherwise payable.

C. Anti-kickback Statute - Under the federal Anti-kickback statute, it is a felony for a person to knowingly and willfully offer, pay, solicit, or receive anything of value (*i.e. "*remuneration"), directly or indirectly, overtly or covertly, in cash or in kind, in return for a referral or to induce generation of business reimbursable under a federal care program. The statute prohibits the offering or payment of remuneration for patient referrals, as well as the offer or payment of anything of value in return for purchasing, leasing, ordering, or arranging for, or recommending the purchase, lease, or ordering of any item or service that is reimbursable by a federal health care program. Individuals found guilty of violating the anti-kickback statute may be subject to fines, imprisonment, and exclusion from participation in federal health care programs.

There are certain statutory exceptions to the Anti-kickback statute. Under one exception, "remuneration" does not include a discount or other reduction in price obtained by a provider of services or other entity if the reduction in price is properly disclosed and reflected in the costs claimed or charges made by the provider or entity under a federal care program.
In addition to the statutory exceptions, the OIG has identified several "safe harbors" for common business arrangements, under which the anti-kickback provision would not be violated. The list of safe harbors is not exhaustive, and legitimate business arrangements exist that that do not comply with a safe harbor.

D. Stark Laws - The Stark laws prohibit certain physician referrals for designated services that may be paid for by Medicaid or other state care plans. The Stark law provides that if a physician (or an immediate family member of a physician) has a "financial relationship" with an entity, the physician may not make a referral to the entity for the furnishing of designated services for which payment may be made under Medicaid. A "financial relationship" under the Stark law consists of either (1) an "ownership or investment interest" in the entity or (2) a "compensation arrangement" between the physician or immediate family member and the entity.

The Stark law includes many exceptions, which may apply to ownership interests, compensation arrangements, or both. Unlike the Anti-Kickback laws which recognize that arrangements falling outside of the safe harbors may still be permitted, the Stark law is a strict prohibition against self-referrals. Accordingly, if a referral arrangement does not meet one of the exceptions, it will be considered unlawful.

Violators of the Stark law may be subject to various sanctions, including a denial of payment for relevant services and a required refund of any amount billed in violation of the statute that had been collected. In addition, civil monetary penalties and exclusion from participation in Medicaid and Medicare programs may apply. A civil penalty not to exceed $15,000, and in certain cases not to exceed $100,000, per violation may be imposed if the person who bills or presents the claim "knows or should know" that the bill or claim violates the statute or investment interest in any entity providing the designated health care service." A "compensation arrangement" is generally defined as an arrangement involving any remuneration between a physician (or an immediate family member of such physician) and an entity, other than certain arrangements that are specifically mentioned as being excluded from the reach of the statute.

E. Civil Monetary Penalties Law - The Office of the Inspector General of the Department of and Human Services (OIG) is authorized to impose civil penalties on any person, including an organization or other entity that knowingly presents or causes to be presented to a federal or state employee or agent false or fraudulent claims. Examples of actions that would give rise to penalties include submitting a claim for services that were not rendered or providing services that were known to be not medically necessary. In addition to specified monetary penalties, treble damages may also be assessed against any person who submits a false or fraudulent claim.

F. Section 1128B of the Social Security Act – This section of the Social Security Act provides for criminal penalties involving federal health care programs. Under this section, certain false statements and representations, made knowingly and willfully, are criminal offenses. For example, it is unlawful to make or cause to be made false statements or representations in either applying for benefits or payments or determining rights to benefits or payments under a federal health care program. In addition, persons who conceal any event affecting an individual's right to receive a benefit or payment with the intent to either fraudulently receive the benefit or payment (in an amount or quantity greater than that which is due), or convert a benefit or payment to use other than for the use or benefit of the person for which it was intended may be criminally liable. Individuals who violate this statute may be guilty of a felony, punishable by a fine of up to $25,000, up to five years' imprisonment, or both. Other persons involved in connection with the provision of false information to a federal health care program may be guilty of a misdemeanor and may be fined up to $10,000 and imprisoned for up to one year.

The Social Security Act also provides the OIG with the authority to exclude individuals and entities from participation in federal programs. Exclusions from federal programs are mandatory under certain circumstances, and "permissive" in others (*i.e.*, OIG has discretion in whether to exclude an entity or individual).

Examples of fraud, waste and abuse include, without limitation, any one combination of, or all of the following:

- Providers, other CCOs, or Subcontractors that intentionally or recklessly report Encounters or services that did not occur, or where products were not provided.

- Providers, other CCOs, or Subcontractors that intentionally or recklessly report overstated or up coded levels of service.
- Providers, other CCOs, or Subcontractors intentionally or recklessly billed EOCCO or OHA more than the usual charge to non-Medicaid recipients or other insurance programs.
- Providers, other CCOs, or Subcontractors altered, falsified, or destroyed clinical records for any purpose, including, without limitation, for the purpose of artificially inflating or obscuring such provider's own compliance rating or collecting Medicaid payments otherwise not due. This includes any intentional misrepresentation or omission of fact(s) that are material to the determination of benefits payable or services which are covered or should be rendered, including dates of service, charges or reimbursements from other sources, or the identity of the patient or provider.
- Providers, other CCOs, or Subcontractors that intentionally or recklessly make false statements about the credentials of persons rendering care to Members.
- Providers, other CCOs, or Subcontractors that intentionally or recklessly misrepresent medical information to justify Referrals to other networks or out-of-network Providers when such parties are obligated to provide the care themselves.
- Providers, other CCOs, Subcontractors that intentionally fail to render medically appropriate covered services that they are obligated to provide to Members under this Contract, any subcontract with the EOCCO, or applicable law.
- Providers, other CCOs, or Subcontractors that knowingly charge Members for services that are covered services or intentionally or recklessly balance-bill a Member the difference between the total fee-for-service charge and EOCCO's payment to the provider, in violation of applicable law.
- Providers, other CCOs, or Subcontractors intentionally or recklessly submitted a claim for payment when such party knew the claim: (1) had already been paid by OHA or EOCCO, (2) had already been paid by another source.
- Any case of theft, embezzlement or misappropriation of Title XIX or Title XXI program money.
- Any practice that is inconsistent with sound fiscal, business, or medical practices, and which: (1) results in unnecessary costs, (2) results in reimbursement for services that are not medically necessary, or (3) fails to meet professionally recognized standards for health care.
- Evidence of corruption in the enrollment and disenrollment process, including efforts of EOCCO employees, State employees, other CCOs, or Subcontractors to skew the risk of unhealthy Member or potential Members toward or away from

EOCCO or any other CCO.

Attempts by any individual, including EOCCO's employees, Providers, Subcontractors, other CCOs, EOCCO, or State employees or elected officials, to solicit kickbacks or bribes. For illustrative purposes, the offer of a bribe or kickback in connection with placing a Member into a carved-out program, or for performing any service that such persons are required to provide under the terms of such persons' employment, this Contract, or applicable law.

Applicable State Laws

A. ORS 411.675 - Under Oregon law, no person shall obtain or attempt to obtain for personal benefit or the benefit of any other person, any payment for furnishing any need to or for the benefit of any public assistance recipient by knowingly: (1) submitting or causing to be submitted to the Department of Human Services any false claim for payment; (2) submitting or causing to be submitted to the department any claim for payment which has been submitted for payment already unless such claim is clearly labeled as a duplicate; (3) submitting or causing to be submitted to the department any claim for payment which is a claim upon which payment has been made by the department or any other source unless clearly labeled as such; or (4) accepting any payment from the department for furnishing any need if the need upon which the payment is based has not been provided to or for the benefit of a public assistance or medical assistance recipient. Violation of this law is a Class C Felony.

B. ORS 411.690 – Any who accepts from the Department of Human Services any payment made to such person for furnishing any need to or for the benefit of a public assistance recipient shall be liable to refund or credit the amount of such payment to the department if such person has obtained or subsequently obtains from the recipient or from any source any additional payment received for furnishing the same need to or for the benefit of such recipient. However, the liability of such person shall be limited to the lesser of the following amounts: (a) The amount of the payment so accepted from the department; or (b) the amount by which the aggregate sum of all payments so accepted or received by such person exceeds the maximum amount payable for such need from public assistance funds under rules adopted by the department.

   Any person who after having been afforded an opportunity for a contested case hearing pursuant to Oregon law, is found to violate ORS 411.675 shall be liable to the department for treble the amount of the payment received as a result of such violation.

C. Oregon False Claims Act and False Claims for Health Care Payments Act – The Oregon False Claims Act (“OFCA”) is a civil statute designed to help the state government combat fraud and recover losses resulting from fraud against public agencies. (Or. Rev. Stat. Ann. § § 180.765 to 180.785). Also, Oregon has a False Claims for Health Care Payments Act (“OFCHCP”) (O.R.S. §§165.690 to 165.698) which works to fight false claims for health care payments.

   Violations of the OFCA include: (1) presenting or causing to be presented for payment or approval a claim that the person knows is false; (2) in the course of presenting a claim for payment or approval, making or using a false record or statement that the person knows to contain, or to be based on, false or fraudulent information; (3) agreeing or conspiring with other persons to present for payment or approval a claim that the person knows is a false claim; (4) delivering, or causing to be delivered, property to a public agency in an amount the person knows is less than the amount for which the person receives a certificate or receipt; (5) making or delivering a document certifying receipt of property used by a public agency, or intended to be used by a public agency, that the person knows contains false or fraudulent information; (6) buying property of a public agency from an officer or employee of a public agency if the person knows

that the officer or employee is not authorized to sell the property; (7) receiving property of a public agency from an officer or employee of the public agency as a pledge of an obligation or debt if the person knows that the officer or employee is not authorized to pledge the property; (8) making or using, or causing to be made or used, a false or fraudulent statement to conceal, avoid or decrease an obligation to pay or transmit moneys or property to a public agency if the person knows that the statement is false or fraudulent; or (9) failing to disclose a false claim that benefits the person within a reasonable time after discovering that the false claim has been presented or submitted for payment or approval.

The OFCA does not contain provisions that allow individuals (or qui tam plaintiffs) with original information concerning fraud to file a lawsuit on behalf of the state. Actions may be brought by the Oregon Attorney General on behalf of the state. All damages assessed for violations of the OFCA are awarded to the state. Similarly, violations of the OFCHCP may be prosecuted only by the district attorney or the Attorney General.

A claim for violating the OFCA will be brought within three years after the date that the officer or employee of the public agency charged with responsibility for the claim discovers the violation. Courts are instructed to award to the state all damages arising from a violation of the OFCA, as well as a penalty equal to the greater of $10,000 for each violation or an amount equal to twice the amount of damages incurred for each violation. Courts may also award attorney's fees and costs of investigation, preparation and litigation to the state if the state prevails. Damages are calculated using the market value of the property, services or benefits obtained by the person who made the claim at the time and place of receipt or delivery. If the market value cannot be established, damages may be calculated using the replacement value or through another measure that reasonably estimate damages incurred.

The penalty portion of the award may be mitigated if the defendant is also subject to fines or penalties for substantially the same acts and omissions under the Federal False Claims Act or the Federal Civil Monetary Penalties Law. In addition, the penalty may not be imposed if the defendant (1) provided the Attorney General with all the information known to the defendant about the violation within 30 days of acquiring the information, (2) fully cooperated with the Attorney General in the investigation, and (3) at the time the defendant provided the Attorney General with information about the violation, a court proceeding or administrative action related to the violation had not commenced. If a court finds that an act or omission of an individual on behalf of a corporation constituted a violation of OFCA, the court may impose a separate penalty against both the individual and the legal entity.

Although the OFCHCP does not have its own set of penalties, the statute requires that the prosecuting attorney will notify the Oregon Health Authority and any appropriate licensing boards of a person convicted under the OFCHCP.

The Act generally requires that the contractor have knowledge of the false or fraudulent information. The knowledge of the contractor can be established if the contractor has actual knowledge, acts in deliberate ignorance of the false or fraudulent nature or acts in reckless disregard of the false and fraudulent nature of the claim.

If the contractor violates the Act, the Attorney General of the State of Oregon can seek damages arising from a violation of the Act, plus the Court is required to award a penalty against the contractor for $10,000 per violation or an amount equal to twice the amount of damages incurred for each violation. EOCCOs can reduce their liability for fully cooperating with the Attorney General. The Attorney General can also be awarded reasonable attorneys' fees. Attorneys' fees can only be awarded against the Attorney General if the Attorney General had no "objectively reasonable basis" for bringing the action.

The Act also provides the Attorney General's office with the broad powers of performing an investigation of whether a violation of the Act has occurred before a lawsuit is filed. The AG's can initiate an investigation, require individuals to appear and testify under oath, issue written discovery requests, and require production of documents requested by the Attorney General's office.

D. OAR 410-120-1380(1)(c)(B) – Any provider entity that receives or makes annual payments under the Title XIX State Plan of at least $5,000,000, as a condition of receiving such payments, shall: (i) Establish written policies for all employees of the entity (including management), and of any contractor, subcontractor, or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter38 of title 31, United States Code, any Oregon State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblowing protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal care programs (as defined in section 1128B(f)); (ii) Include as part of written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste and abuse; and (iii) Include in any employee handbook for the entity, a specific discussion of the laws described in (i), the rights of the employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

E. ORS 165.080 (falsification of business records) - A person commits the crime of falsifying business records if, with intent to defraud, the person (a) Makes or causes a false entry in the business records of an enterprise; or (b) Alters, erases, obliterates, deletes, removes or destroys a true entry in the business records of an enterprise; or (c) Fails to make a true entry in the business records of an enterprise in violation of a known duty imposed upon the person by law or by the nature of the position of the person; or (d) Prevents the making of a true entry or causes the omission thereof in the business records of an enterprise.

F. ORS 659A.200 to 659A.224 protect public employees who disclosing fraud in good faith. More specifically, they prohibit a public employer from preventing an employee from discussing with the legislature the activities of a public agency or those authorized to act on behalf of a public agency. Employers may also not take or threaten to act against an

employee who discloses any information the employee reasonably believes is a violation of law or evidence of mismanagement, gross waste of funds or abuse of authority. Employers may not require an employee to give notice prior to making any disclosure except that an employer may require the employee to give advanced notice of any testimony given as part of a legislative request to the agency.

G. OAR 410-120-1395 to 410-120-1510.
   1. OAR 410-120-1395 identifies the approaches taken by the Department of Human Services to promote program integrity.
   2. OAR 410-120-1397 describes the basis for denying claims payment and the process for recouping payments or obtaining refunds of payments to Providers.
   3. OAR 410-120-1400 and 410-120-1460 describe the basis for imposing sanctions and the types and conditions of sanctions for violations of Federal and State statutes and regulations related to fraud and abuse.
   4. 410-120-1510 describes the right to and the process for auditing provider payments.
   5. 410-120-1510 sets forth requirements for detecting and investigating fraud and abuse.

Definitions

The terms below shall have the following meanings and shall apply when used:

- with a possessive case (such as "'s" or "s'"),
- in noun form when defined as a verb or vice versa,
- used in a phrase or with a hyphen to create a compound adjective or noun,
- with a participle (such as "-ed" or "-ing"),
- with a different tense than the defined term,
- in plural form when defined as singular and vice versa.

References to "they" when used in the singular or plural tense shall refer to all genders.

Terms not capitalized, whether or not listed below, shall have their commonly understood meaning and usage, including as applicable, the meaning as understood within the health care field and community.

Abuse means has the meaning provided for in 42 CFR §455.2

Encounter data means certain information required to be submitted to OHA under OAR 410-141-3570 and related to services that were provided to Members regardless of whether the services provided: (i) were Covered Services, non-covered services, or other Health-Related services, (ii) were not paid for, (iii) paid for on a Fee-For-Service or capitated basis, (iii) were performed by a Participating Provider, Non-Participating Provider, Subcontractor, or Contractor, and (iv) were performed pursuant to Subcontractor agreement, special arrangement with a facility or program; or other arrangement.

Fraud means the intentional deception or misrepresentation that Person knows, or should know, to be false, or does not believe to be true, and makes knowing the deception could result in some unauthorized benefit to themselves or some other Person(s).

Member means a client who is enrolled with Contractor under the Contract.

Participating Provider has the meaning as provided in OAR 410-141-3500(56).

Provider has the meaning as provided in OAR 410-120-0000(204)

Subcontractor means any individual, entity, facility, or organization, other than a Participating Provider, that has entered into a Subcontract with the Contractor or with any Subcontractor for any portion of the Work under the Contract.

Waste means over-utilization of services, or practices that result in unnecessary costs, such as providing services that are not medically necessary.