Subject: Compliance

Objective:

I. To establish Tuality Health Alliance's (THA) commitment to compliance with all Federal and State regulations and statutes governing the Medicaid program.

II. To express a clear expectation that THA compliance standards apply equally to all employees, delegated entities, Board of Directors, vendors, THA provider network, and members regardless of position, rank or tenure with THA.

III. To ensure that THA fosters an atmosphere that encourages and enables the reporting of non-compliance without fear of retaliation or retribution.

IV. To ensure that THA is compliant in identified problem areas such as claims, Prior Authorization (PA), service verification, utilization management, and quality review.

V. To ensure THA has an appropriate process to identify fraud and abuse.

VI. To ensure THA operates in such a way to ensure payment of the correct amount is made to a properly enrolled provider for covered, medically appropriate services provided to an eligible member according to the member's benefit package of healthcare services in effect on the date of service.

Definitions:

Abuse: when provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Authority or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs.

Credible allegation of fraud: an allegation of fraud, which has been verified by THA and has indicia of reliability that comes from any source.

False Claims Act: a Federal law that imposes liability and sets criminal and civil penalties on person(s) or organizations who defraud governmental programs by the submission of a claim for payment to the government that is known to be false in whole or in part.

Fraud: an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Subject: Compliance

Waste: health care spending that can be eliminated without reducing quality of care. It includes insufficient use or management of resources, unnecessary expenses, or procedures that cannot reasonably be expected to yield better outcomes.

Policy:

I. **Applicability**
THA policies apply to all employees and members. It is the responsibility of each employee and member to be familiar with policies, regulations and statutes that apply to their daily work activities and to comply with such policies, regulations and statutes at all times.

II. THA maintains a compliance program which includes a code of conduct for employees and members, as well as policies.

III. All employees and members are responsible for promptly raising concerns about any possible misconduct, including suspected violations of any federal health care program requirements orTHA's policies. This includes potential misconduct of fellow employees or members. Reporting methods include reporting to a direct supervisor, contracting the THA Compliance Officer directly, or using the anonymous compliance hotline numbers listed in this policy.

IV. **Code of Conduct**
Annual employee acceptance of the THA Code of Conduct is a mandatory requirement for employment. Annual acceptance of the THA Membership Compliance Policy is a mandatory requirement for THA network membership.

V. **Retaliation Protection**
THA does not allow THA staff, providers or contractors to intimidate, threaten, coerce, discriminate against, or take any other forms of retaliation against any individual who submits complaints of compliance standards violations, fraud or abuse. This includes participating in any process covered, including the filing of a complaint with THA or with the Oregon Health Authority and any subsequent testimony, investigation participation and assistance, compliance review, proceeding or hearing related. This also includes opposing any unlawful act or practice provided the individual (including an employee) believes in good faith that the act or practice being opposed is unlawful; and that the manner of such opposition is reasonable and does not involve a use or disclosure of an individual's protected information in violation of the Health Insurance Privacy and Portability Act (HIPPA) or THA policy.

Subject: Compliance

VI. **Non-compliance**
Failure by any employee to comply with applicable regulation, statute, or THA policies, will result in disciplinary action up to and including dismissal from employment. Failure by any member to comply with applicable regulation, statute, or THA policies, will result in possible termination from the THA network.

VII. THA prohibits any act of intentional deception or misrepresentation made by a person that has knowingly acted with the knowledge that the deception(s) could result in some unauthorized benefit. The term "knowingly", in the context of the False Claims Act means that a person, with regard to specific information:

- Has actual knowledge of the information;
- Acts in deliberate ignorance of the truth or falsity of the information; or
- Acts in reckless disregard to the truth or falsity of the information.

VIII. THA does not contract with or reimburse providers which engage in inconsistent and/or unsound fiscal, business or medical practices that may result in unnecessary costs to THA or that fail to meet professionally recognized standards for healthcare reimbursement. If THA is contracted with an individual provider or organization that commits fraud and/or abuse, THA will report the fraudulent activities as outlined in this policy and take other necessary action up to and including terminating the applicable contract.

IX. If providers are suspended or terminated by the Oregon Health Authority or Centers for Medicare and Medicaid Services, THA will assist members with finding a new provider.

X. **THA Compliance Officer**

A. THA has appointed the THA Provider Relations Representative as THA's Compliance Officer. THA's Compliance Officer reports directly to the THA Director and Board of Directors on compliance related matters. The Compliance Officer is responsible for ensuring the proper operation and monitoring of the fraud and abuse program. The THA Compliance Officer is responsible for developing the compliance education training curriculum, monitoring the fraud and abuse program, monitoring and ensuring that compliance training meets the program applicable Federal and State standards.

B. Employees, members, providers, vendors or contractors may immediately and anonymously report suspected violations without fear of retaliation.

Subject: Compliance

THA's Compliance Officer can be contacted via email (compliance@tuality.org) or telephone (503-681-1166) or through Tuality Healthcare's Compliance Hotline (503-681-1970).

C. The THA Compliance Officer maintains a leadership role that is recognized and promoted by senior leadership. The THA Compliance Officer participates regularly in senior management meetings and provides information on compliance-related matters. Additionally, regular and ad hoc reports are given to the THA Director regarding areas of risk facing the organization, strategies being implemented to address these risk areas, and the results of those strategies. The THA Director is also regularly apprised of all governmental compliance enforcement activity.

D. The THA Compliance Officer is responsible for the day to day operation of the compliance program, including:
   a. Handling inquiries from employees regarding any aspect of compliance;
   b. Investigating any information or allegation concerning possible unethical or improper business practices and recommending corrective action when necessary;
   c. Planning and overseeing regular, periodic audits of the company's operations to identify and rectify any possible barriers to the efficacy of the compliance program;
   d. Monitoring activities to verify the effectiveness of the program; and
   e. Managing all corporate policies.

E. Communication lines to the THA Compliance Officer are accessible to all employees and members. Anonymous and good faith reporting of potential compliance issues is available to all employees and members. Reports of potential compliance issues may be made at any time to the THA Compliance Officer, Director, Managers, or Supervisor. If reports of compliance issues are provided to anyone other than the THA Compliance Officer, the person receiving the report will provide a report to the THA Compliance Officer, such that the THA Compliance Officer can track and log the report and ensure that a complete investigation is conducted.

F. Violations of THA's compliance program threaten our status as a reliable, honest and trustworthy company. For this reason, the THA Compliance Officer will promptly respond to and investigate any and all reports of non-compliance.
   i. Reports of such investigations will contain documentation of alleged violation, a description of the investigative process, copies of interview notes and key documents, and the results of the investigation.

Subject: Compliance

ii. If the THA Compliance Officer discovers credible evidence of misconduct and has reason to believe the misconduct may violate criminal, civil or administrative law, the THA Compliance Officer shall promptly report the existence of such misconduct to the appropriate governmental authority, demonstrating THA's good faith and willingness to work with government authorities to correct and remedy the problem.

iii. Failure to report suspected violations of this policy, participating in non-compliant behavior or encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior will be subject to disciplinary action appropriate to the circumstances of the violation. THA will consider the impact of the violation on THA's operations and reputation, whether the violation was accidental or intentional, and whether Federal or State laws were violated.

G. The THA Board of Directors is actively engaged in the reasonable oversight of the compliance program. The THA Compliance Officer regularly reports to executive leadership and the THA Board of Directors at each meeting concerning the compliance activities and actions taken following the last meeting, planned compliance activities and any compliance program modifications determined necessary.

XI. **Fraud, Waste & Abuse**

THA has established a system for routine identification and oversight of compliance risks. The system includes internal audits and monitoring for compliance with Federal and State requirements, assists in the reduction of fraud and abuse activities, and the overall effectiveness of the compliance program. Ongoing monitoring is performed to ensure that corrective actions are undertaken when risks are identified, and that those actions are effective in mitigating the risk.

A. Education

A formal compliance training program, including fraud, waste and abuse, privacy, and confidentiality is provided to all THA staff within 90 calendar days of hire and again annually. Training and education is provided on expectation regarding employee responsibility for compliance, addressing compliance issues identified, and the operation of the compliance program.

B. Ongoing Monitoring

Preventing Submission of False Claims

The THA Claims Management system uses software to detect inconsistent billing practices, referred to as "clinical edits". THA denies any submitted claim that is not billed correctly and/or discontinues paying

Subject: Compliance

claims filed with inconsistent billing. The software also allows THA to detect/deny false claims submitted on behalf of members that do not exist and/or who are not eligible for benefits.

Explanation of Medical Benefit Questionnaires
THA compiles a random sample of members who have received services every 45 days. This sample is based on paid claims from a randomly selected month and a randomly selected date of birth. The sample members are each mailed an Explanation of Medical Benefit (EOMB) Questionnaire. The EOMB Questionnaire includes the selected date of service(s), the type of service(s) received, and the name of the provider who delivered the service(s) and inquires:

- Did you pay for anything?
- Did you receive all of the services listed?
- If you did pay, did you get your money back?
- What is your telephone number?

The member is provided a postage-paid envelope in which to return the completed questionnaire to THA. All EOMB distribution lists are maintained by THA Member Services.

If a member contacts THA or submits an EOMB claiming they have been billed for services, THA Member Service reviews the details of the charges to verify that the member truly received the billed services. The Provider in question is contacted to verify the billed information and/or member payment. If there continues to be a discrepancy between the member and the Provider, chart notes will be requested and reviewed by THA Nurse Case Management.

Upon request from the Oregon Department of Human Services, THA will provide verification that Oregon Health Plan members were contacted to confirm that billed services were provided. Shared information shall not include protected information such as genetic information, mental health status, alcohol and drug use, or HIV/AIDS infection. Shared information will specify:

- The service furnished;
- The name of the provider furnishing the service;
- The date on which the service was furnished;
- The amount of the payment made by the Oregon Health Plan; and
- The name of the member.

Other areas of monitoring/auditing
In addition to the above, THA staff conducts at least quarterly audits, utilizing audit tools and sample sizes evaluate adherence to THA policies in the following areas:

Subject: Compliance

- Utilization of services;
- Referral and Prior Authorizations (medical appropriateness of services or items);
- Provider Record Review (medical records compared to submitted claims);
- Provider Site Review;
- Grievance and Appeals (indication of potential Fraud, Waste or Abuse); or
- National Practitioner Data Bank (negative reports on Providers).

If an area scores less than 95% accuracy, the failure will be evaluated by THA leadership and affected THA staff will be educated to improve compliance. If warranted, corrective action and/or discipline administered.

XII. **Fraud, Waste & Abuse Reporting**

As part of THA's efforts to prevent potential fraud and abuse activities, THA responds promptly to allegations of improper or illegal activities and enforces appropriate disciplinary actions against employees, providers or contractors found to be violating applicable fraud and abuse policies, applicable Federal and State regulations or statutes, and other Federal or State health care requirements.

A. If a situation of fraud and/or abuse by a provider is suspected, prompt referral to the Oregon Department of Justice Medicaid Fraud Control Unit and Oregon Department of Human Services Provider Fraud Unit is required.

Oregon Department of Justice
Medicaid Fraud Control Unit
1515 SW 5th Avenue, Suite 410
Portland, OR 97201
(971) 673-1880
Medicaid.fraud.referral@doj.state.or.us

Oregon Department of Human Services
Provider Audit Unit
3406 Cherry Avenue NE, 2nd floor
Salem, OR 97303
Phone: (503) 372-8301
Fax: (503) 373-1525 (Attn: HOTLINE)
https://aixxweb1p.state.or.us/es_xweb/OPR_Fraud_Ref/index.cfm?act=evt.subm_web

Subject: Compliance

B. If a situation of fraud and/or abuse by a member is suspected, prompt referral to the Oregon Department of Human Services Investigation unit is required.

Oregon Department of Human Services
Investigation Unit
PO Box 14150
Salem, OR 97309

C. THA will simultaneously report all investigations to the appropriate Federal and State agencies and to Health Share of Oregon.

Health Share of Oregon
2121 SW Broadway Suite 200
Portland, Oregon 97201
Hotline: (503) 416-1459
Fax: (503) 459-5749

XIII. In the event of suspected fraud or abuse, THA will cooperate with Oregon Department of Justice Medicaid Fraud Control Unit and Oregon Department of Human Services Provider Fraud Unit as required.

XIV. THA providers shall permit Health Share of Oregon or THA, together or separately, to inspect copy, evaluate or audit books, records, documents, files, accounts, and facilities, without charge, as required to investigate an incident of fraud or abuse. When a provider fails to provide immediate access to records, payments may be withheld or suspended.

XV. Providers and their fiscal agents shall disclose ownership and control information and disclose information on a provider's owners and other person convicted of criminal offenses against Medicare, Medicaid, Children's Health Insurance Program, or the Title XX services program. Such provider shall update that information if any of the information materially changes.

XVI. THA may suspend payments in whole or in part in a suspected case of fraud or abuse; or where there exists a credible allegation of fraud or abuse presented to THA; or where there is a pending investigation or conclusion of legal proceedings related to the provider's alleged fraud or abuse.

XVII. THA may take actions necessary to investigate and respond to credible allegations of fraud or abuse, including but not limited to suspending or terminating the provider from participation in the THA network, withholding

Subject: Compliance

payments or seeking recovery of payments made to the provider, or imposing other sanctions provided under State regulations or statute.

XVIII. THA shall not pay for covered services provided by persons who are currently suspended, debarred or otherwise excluded from participating in Medicaid, Medicare, Children's Health Insurance Program, or who have been convicted of a felony or misdemeanor related to a crime or violation of Title XVIII, XIX, or XX of the Social Security Act or related laws.

XIX. THA will provide a written copy of its Fraud, Waste, and Abuse policies annually to Health Share per the contractual timeframe.

XX. THA maintains files for a period of ten (10) years on both providers who have been the subject of grievances, investigations, violations, and prosecutions. This includes member grievances, Medicaid Fraud Control Unit investigations, Office of the Inspector General and/or Department of Justice investigations, United States Attorney prosecutions, and any other civil, criminal, or administrative action for violations of Federal health care program requirements. THA also maintains files that contain documented warnings (i.e. fraud alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. THA will fully comply with requests by law enforcement, the Centers for Medicare and Medicaid Services or its designee regarding monitoring providers within the network that have been identified as potentially engaging in fraud or abuse.

References: 42 CFR 433.116
42 CFR 438.214
42 CFR 438.600 - 438.610
42 CFR 438.808
42 CFR 455.20
42 CFR 455.23
42 CFR 455.100 - 455.106
42 CFR 1002.3
31 USC §3729-3733
ORS 124.050
ORS Chapter 162
ORS 165.690-165.698
ORS 411.010 - 411.081
ORS 411.670-411.690
ORS 659A.200 - 659A.224
OAR 410-120-0000
OAR 410-120-1510
OAR 410-120-1395 - 410-120-1510

Formulated:	September 2000
Reviewed:	September 2009 July 2013 January 2014 January 2015
Revised	July 2004 May 2004 April 2006 July 2008 September 2008 October 2010 January 2011 May 2012 December 2015 November 2016 April 2018

Subject: Compliance

OAR 410-141-0080 (2)(a)
Oregon Health Authority Coordinated Care Organization Contract
Health Share of Oregon-Tuality Health Alliance Contract