EXHIBIT J
PREVENTION/DETECTION OF FRAUD AND ABUSE

Contractor shall have in place internal controls, policies or procedures capable of preventing and detecting fraud and abuse activities as they relate to the Oregon Health Plan. This may include operational policies and controls in areas such as complaint and grievance resolution, provider credentialing and contracting, provider and staff education, and corrective action plans to prevent potential fraud and abuse activities. Contractor shall review its fraud and abuse policies annually. If Contractor is also a Medicare contractor, the fraud and abuse policies established by Contractor to meet CMS standards shall be deemed sufficient to meet DHS's requirements for fraud and abuse prevention and monitoring. Fraud and Abuse policies and procedures shall be reviewed annually. Contactor shall submit to AMH for review and approval written Fraud and Abuse policies and procedures, due within 30 days of the effective date of this agreement.

1. Contractor's fraud and abuse activities shall include, at minimum, the following:

   (a) Written policies, procedures, and standards of conduct that articulate Contractor's commitment to comply with all applicable Federal and state standards to guard against fraud and abuse;

   (b) 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 chapter 38 of title 31, United States Code, any Oregon laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in 42 USC 1320a-7b);

   Such Oregon laws shall include the following: ORS 411.670 to 411.690 (submitting wrongful claim or payment prohibited; liability of person wrongfully receiving payment; amount of recovery); ORS 646.505 to 646.656 (unlawful trade practices); ORS chapter 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 (whistleblowing); ORS 659A.230 to 659A.233(whistleblowing); OAR 410-120-1395 to 410-120-1510 (program integrity, sanctions, fraud and abuse); and common law claims founded in fraud, including Fraud, Money Paid by Mistake and Money Paid by False Pretenses).

Contractor understands that this description of the laws that must be included in the employee handbook under this Section of the Contract does not limit the authority of DMAP or any health oversight agency or law enforcement entity from fully exercising its legal authority or from pursuing legal recourse to the full extent of the law.

(c) Provide as part of the written policies, detailed provisions regarding the Contractor's policies and procedures for detecting and preventing fraud, waste and abuse.

(d) Include in any employee handbook for the Contractor, a specific discussion of the laws described in subsection (b) of this section, the rights of employees to be protected as whistleblowers, and the Contractor's policies and procedures for detecting and preventing fraud, waste and abuse.

(e) The designation of a compliance officer and a compliance committee that are accountable to senior management, to monitor fraud and abuse activities;

(f) Effective training and education for the compliance officer and Contractor's employees;

(g) Effective lines of communication between the compliance officer and Contractor's employees;

(h) Enforcement of standards that guard against fraud and abuse through well publicized disciplinary guidelines;

(i) Provision for internal monitoring and auditing; and

(j) Provision for prompt response to detected offenses and for development of corrective action initiatives relating to this MHO Agreement.

2. Services under this Agreement may not be provided by the following persons (or their affiliates as defined in the Federal Requisition Regulations): (a) Persons who are currently suspended, debarred or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issues pursuant to Executive Order No. 12549 or under guidelines implementing such order, (b) Persons who are currently excluded from the Medicaid participation under section 1128 or section 1128A of the Act.

3. Contractor shall not refer OHP Members to such persons and shall not accept billings for services to OHP Members by such persons.

4. Contractor may not knowingly: (1) have a person described in (a) above as a director, officer, partner, or person with beneficial ownership of more than 5% of Contractor's equity, or (2) have an employment, consulting, or other agreement with a person described in 1(a) above for the provision of items and services that are significant and material to Contractor's obligations under this Agreement.

5. Contractor is required to promptly refer all verified cases of fraud and abuse, including fraud by employees and subcontractors of the organization to the Medicaid Fraud Control Unit (MFCU), consistent with the Memorandum of Understanding between DHS and the MFCU. Contractor may also refer cases of suspected fraud and abuse to the MFCU prior to verification.

6. Examples of cases that should be referred:

   (a) Providers who consistently demonstrate a pattern of intentionally reporting encounters or services that did not occur. A pattern would be evident in any case where 20% or more of sampled or audited services are not supported by documentation in the clinical records;

   (b) Providers who consistently demonstrate a pattern of intentionally reporting overstated or up-coded levels of service. A pattern would be evident by 20% or more of sampled or audited services that are billed at a higher level procedure code than is documented in the clinical records;

   (c) Any verified case where the provider purposefully altered, falsified, or destroyed clinical record documentation for the purpose of artificially inflating or obscuring compliance rating or collecting Medicaid payments not otherwise due;

   (d) Providers who intentionally or recklessly make false statements about the credentials of persons rendering care to OHP Members;

   (e) Providers who intentionally fail to render medically appropriate covered services to OHP Members;

   (f) Providers who knowingly charge OHP Members for services that are covered or intentionally balance bill an OMAP Member the difference between the service charge and Contractor's payment, in violation of DHS rules;

   (g) Any case of theft, embezzlement or misappropriation of Title XIX or Title XXI program money.

7. An incident with any of the referral characteristics listed above should be referred to the MFCU. Contractor may also refer cases of suspected fraud and abuse to the MFCU.

8. The MFCU phone number is (503) 229-5725, address 1515 SW 5th Avenue, Suite 410, Portland, Oregon 97201, and fax (503) 229-5120.

9. Incidents of verified or suspected fraud or abuse by an OHP Member should be reported to DHS Fraud Investigation Unit, P.O. Box 14150, Salem, Oregon 97309-5027, phone number (503) 378-6826, facsimile number (503) 373-1525.

10. Contractor shall promptly report all fraud and abuse as required under this section to the MFCU. Contractor shall also notify AMH of referrals to MFCU of complaints of fraud and abuse that warrant investigation. This notification shall include the following information:

11. Contractor shall promptly report all fraud and abuse as required under this section to the MFCU. Contractor shall also notify AMH of referrals to MFCU of complaints of fraud and abuse that warrant investigation. This notification shall include the following information:

    (a) Provider’s name, Oregon Medicaid Provider Number, and address;

    (b) Type of Provider

    (c) Source of complaint;

    (d) Nature of complaint;

    (e) The approximate range of dollars involved;

    (f) The disposition of the complaint when known; and

    (g) Number of complaints for the time period.

12. Contractor shall cooperate with the MFCU and the DHS Fraud Unit 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.

13. In the event that Contractor reports suspected fraud, or learns of an MFCU or DHS Fraud Unit investigation, Contractor shall not notify or otherwise advise its subcontractors of the investigation so as not to compromise the investigation.