eocco EASTERN OREGON COORDINATED CARE ORGANIZATION		**Policy & Procedure**			
Company:	EOCCO	**Department Name:**		EOCCO Quality Improvement Committee	
Subject:	EOCCO Code of Conduct				
P & P Original Effective Date:	07/31/2019	**P &P Origination Date:**	7/31/2019	**P & P Published Date:**	01/01/2023
P & P Revision Effective Date:		**P & P Revision Published Date:**		01/01/2024	
Reference Number:		**Next Annual Review Date:**		9/1/2024	
Product (check all boxes applicable to this policy) ☒Dental ☒ Medical ☒ Pharmacy ☒ Behavioral Health					

I. Policy Statement and Purpose

A. The Code of Conduct applies to all members of the workforce, and the members of Board. EOCCO will provide a work environment that supports honesty, integrity, and respect in the treatment of workers related to the below areas.

1. ***Ethical Conduct and Compliance:*** In the performance of duties, staff members will set an example of ethical behavior, and comply with all laws and regulations that govern our business. Staff must never sacrifice ethical and compliant behavior in the pursuit of business objectives.
2. **Business and Financial Information:** Accuracy, Retention and Disposal of Documents and Records: You are responsible for the integrity and accuracy of any organizational documents or records that you write or modify. Falsifying or altering documents or records is absolutely prohibited. This includes improperly back-dating documents. You are also expected to become familiar with and comply with policies and procedures that address the retention and disposal of the organization's documents and records.
3. **Financial Reporting and Records:** In order to provide accurate and reliable financial records, all financial transactions shall be recorded and according to generally accepted accounting principles (GAAP) and EOCCO policies and procedures. We have implemented internal controls to provide reasonable assurance that management has authorized a transaction and that it has been properly recorded.
4. **Confidentiality of Business and Member Information:** It is your ethical duty to protect the confidentiality of information about trade secrets, confidential business plans, and proprietary business information. When in doubt about whether or not you may share such information, contact the CEO or Chief Compliance Officer. You are also expected to comply with policies and procedures regarding the confidentiality of member health information. Identifiable member information shall not be shared with others who do not have a legitimate need to know in order to perform their specific job or to carry on business. The use of member, worker or any individual's or entity's information for personal benefit is absolutely prohibited.
5. ***Treatment of others:*** EOCCO prohibits all forms of discrimination, including harassment of any kind. Members of the staff shall be treated with dignity and respect, regardless of their age, gender, gender identity, race, ethnicity, national origin, religion, sexual orientation, disability, socioeconomic status, or any other basis protected by applicable law.
6. ***Conflict of Interest:*** A conflict of interest occurs when personal interests could interfere with your ability to make a fair and objective decision on behalf of EOCCO, or create opportunities for fraud or self-

enrichment. You should avoid relationships and activities that create, or even appear to create, a conflict of interest. At times, an employee may be faced with situations in which business actions taken on behalf of Company may conflict with the employee's own personal interests. Company property, information or business opportunities may not be used for personal gain. If you are unsure whether a conflict of interest exists, you should talk with the person to whom you report or the Chief Compliance Officer.

7. ***Gifts and Gratuities:*** EOCCO staff will not accept items from vendors in excess of $50.00 (fifty dollars) per year, per individual. For perishable or consumable gifts, the aggregate value of the gift may not exceed $1,000.00 (one thousand dollars). Regardless of value, no more than two perishable or consumable gifts may be accepted per vendor per year. For gifts that are not perishable or consumable, the aggregate value of the gift may not exceed $250.00 (two-hundred and fifty dollars). All gifts, gratuities, or other compensation from a vendor must be disclosed to the employee's supervisor or manager, or to the CEO for members of EOCCO's board of directors.
8. ***Personal Use of EOCCO Resources:*** Anything beyond incidental personal use of EOCCO materials, supplies or equipment is prohibited without prior approval from your team leader. You must not remove property from a facility owned or managed by EOCCO without proper authorization. If removed, property must be returned to the facility as soon as practicable, after it is no longer needed for authorized purposes. 411.690(2))

B. **Fraud, Waste and Abuse:**

EOCCO takes health care fraud and abuse very seriously. It is our policy to provide information to all employees, contractors and agents about the federal and state false claims acts, remedies available under these acts and how employees and others can use them, and about whistleblower protections available to anyone who claims a violation of the federal false claims acts. We will also advise our employees, contractors, and agents of the steps EOCCO has put in place to detect health care fraud and abuse. The Federal False Claims Act is a federal law that imposes liability on persons and companies who defraud governmental programs. It is the federal government's primary litigation tool in combating fraud against the government. The law includes a *qui tam* provision that allows people who are not affiliated with the government, called "relators" under the law, to file actions on behalf of the government (informally called "whistleblowing").

1. Persons filing under the Act stand to receive a portion of any recovered damages. This statute allows a civil action to be brought against a health care provider who:
   a. Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to any federal employee;
   b. Knowingly makes, uses or causes to be made or used a false record or statement to get a false or fraudulent claim paid; or
   c. Conspires to defraud the government by getting a false or fraudulent claim allowed or paid (31 USC SEC 3729(a)).
2. **Examples of a False Claim:** Billing for procedures not performed; Up-coding health care services; Falsifying information in the medical record

   Remedies: A federal false claims action may be: brought by the U.S. Department of Justice, or brought by an individual as a *qui tam* action(this means the individual files an action on behalf of the government); punishable by a civil penalty of between $10,781 and $21,563 per false claim, plus three times the amount of damages incurred by the government; and subject to a statute of limitations that controls how much time may pass before an action may no longer be brought for violation of the law. Under the False Claims Act, the statute of limitations is six (6) years after the date of violation or three (3) years after the date when material facts are known or should have been known by the government, but no later than ten (10) years after the date on which the violation was committed.
3. **Federal Whistleblower Protections:** Federal Law prohibits an employer from discriminating against an employee who initiated or otherwise assisted in a false claims action. The employee is entitled to all relief necessary to make the employee whole. 31 USC 3730(h)
4. **Oregon Whistleblower Statutes:** Criminal and civil laws that prohibit Medicaid fraud are outlined below. It is a crime if a health care provider knowingly submits, or causes to be submitted, a claim for payment to which the provider is not entitled. ORS 180.755; ORS 411.675; ORS 165.690.692. A healthcare provider is

subject to civil damages if it has been previously warned against certain billing practices. ORS 411.690(2))

5. **Oregon Whistleblower Protections:** Oregon law contains several provisions that prohibit retaliatory action by a healthcare provider against an employee who, in good faith, brings evidence of unlawful practices to the attention of the proper authority. ORS 441.181, ORS 441.057, ORS 659A.233, ORS 659A.203. Further, an employee who believes he or she is the victim of retaliation may file a complaint with the Oregon Bureau of Labor and Industries.
6. **Medicaid Waste and Abuse:** In addition to an intolerance of Medicaid fraud, EOCCO prohibits Medicaid waste and abuse, defined as follows:
    a. **Waste:** The extravagant, careless, or unnecessary utilization of, or payment for, health care services.
    b. **Abuse:** An activity or practice undertaken by a member, practitioner, employee, or contractor that is inconsistent with sound fiscal, business or health care practices and results in unnecessary cost to EOCCO, reimbursement for services that are not medically necessary, or an activity or practice that fails to meet professionally recognized standards for health care.
    c. **Additional Information:** If you have any questions about this information, you may contact the Chief Compliance Officer at (541) 298-2101 or call the Hotline at (800) 773-7237.
    d. **Obeying All Laws:** Members of EOCCO's workforce are required to follow all applicable federal, state and local laws. Any member of the EOCCO workforce who believes himself or herself to have received instructions otherwise must immediately inform the Chief Compliance Officer or members of the EOCCO Board of Directors.

II. Definitions

A. n/a

III. Procedure

A. Reporting Obligation and Resources
    1. Personal Obligation to Report: You are responsible to report any activity that appears to violate applicable laws, rules, regulations, or the Code of Conduct. If you report a concern, but believe that it has not been resolved, contact the Chief Compliance Officer.
    2. Resources for Guidance: We encourage you to discuss concerns with your manager, CEO or President. If you are uncomfortable doing so, you can discuss the situation with the Chief Compliance Officer. You may contact him/her directly or call the Hotline at 1-866-294-5591 or at www.ethicspoint.com. EOCCO cannot guarantee that it will keep your identity confidential if you report a concern or possible misconduct, but we will maintain confidentiality within the limits of the law and our ability to investigate the issues you have brought to our attention. EOCCO absolutely prohibits, and will not tolerate, retaliatory discipline against a worker who reports concerns using the channels described above. Claims of retaliation will be investigated and, if substantiated, appropriate action will be taken. EOCCO takes health care fraud and abuse very seriously. It is our policy to provide information to all employees, contractors and agents about the federal and state false claims acts, remedies available under these acts and how employees and others can use them, and about whistleblower protections available to anyone who claims a violation of the federal false claims acts. We will also advise our employees, contractors, and agents of the steps EOCCO have put in place to detect health care fraud and abuse. An employee, contractor, temporary worker, or volunteer who provides care or has access to clients, client information, or client funds within or on behalf of any entity or agency licensed, certified, registered, or otherwise regulated by the Department or Authority is subject to a standard criminal history check at hire and monthly sanction check.
    3. Procedure for Reporting: If you think that EOCCO may have made a false claim as discussed above, you are encouraged to: Report it to the Chief Compliance Officer at (855) 294-5591 or at www.ethicspoint.com for further investigation. You may also report it directly to the federal Department of Justice; you are not required to report a possible false claims act violation to EOCCO first.
    4. Report any retaliation you may experience from EOCCO if you inform EOCCO or the federal government of a possible false claims act violation to the Federal Department of Justice.
    5. EOCCO Policies and Procedures for Detecting Fraud and Abuse: Policies and procedures for detecting

fraud and abuse are found in the EOCCO Compliance Plan. More detailed information about the False Claims Act is available from the Chief Compliance Officer.

6. Training Policy: EOCCO will train all new members of our workforce, contractors, and agents regarding federal and state false claims acts and also provide periodic updates for existing members of our workforce, contractors, and agents. All members of EOCCO's workforce are required to participate in training. All contractors and agents are required to participate in scheduled training, as determined by Chief Compliance Officer.

IV. Related Policies & Procedures, Forms and References

V. Revision Activity

New P & P /Change / Revision and Rationale	Final Review/Approval	Approval date	Effective Date of Policy/Change
New policy and procedure documenting current practice	EOCCO Quality Improvement Committee	7/31/2019	7/31/2019
Policy to be included in FWA Handbook per 2020 CCO contract	EOCCO Quality Improvement Committee	03/18/2020	01/01/2020
Annual review no changes	EOCCO Policy Subcommittee	12/16/2021	01/01/2022
Annual Review no changes. OHA approval rec'd 11/2022	EOCCO Policy Subcommittee	1/23/2023	01/01/2023
Annual Review no changes.	EOCCO Policy Subcommittee	9/25/2023	01/01/2024

VI. Affected Departments:

eocco EASTERN OREGON COORDINATED CARE ORGANIZATION		**Policy & Procedure**			
Company:	EOCCO	**Department Name:**		Compliance	
Subject:	EOCCO Compliance Committee				
P & P Original Effective Date:	01/01/2020	**P &P Origination Date:**	01/01/2020	**P & P Published Date:**	01/01/2023
P & P **Revision Effective Date:**		**P & P Revision Published Date:**		01/01/2024	
Reference Number:		**Next Annual Review Date:**		9/1/2024	
Product (check all boxes applicable to this policy) ☒Dental ☒ Medical ☒ Pharmacy ☒ Behavioral Health					

I. Policy Statement and Purpose

A. EOCCO will have a regulatory compliance committee which will be responsible for overseeing EOCCO's fraud, waste, and abuse prevention program and compliance with the terms and conditions of the OHA Health Plan Services Contract.

B. Members of the compliance committee include EOCCO's compliance officer, senior level management employees, and members of the board of directors. The members of EOCCO's Regulatory Compliance Committee are:

- Nick Gross, EOCCO Chief Compliance Officer (Chair)
- Seah Jessup, CEO, EOCCO
- Harold Geller, CEO St. Anthony Hospital, EOCCO Board Member
- James Williams, Lake County Commissioner, EOCCO Board Member
- Kayla Jones, Manager, Medicaid Services
- Summer Prantl, Senior Manager, Medicaid Services
- Beth Graham, Supervisor, Appeals and Grievance Department
- Karen Cady, GOBHI Compliance Officer

II. Definitions

N/A

III. Procedures

The EOCCO Regulatory Compliance Committee shall facilitate the Board of Directors' effective oversight of the organization's compliance program, engagement in compliance issues impacting the organization's Medicaid business, and provision of support and resources for the organization's Compliance Officer. The

EOCCO Compliance Officer will serve as chair of the committee. Responsiblities of the committee include:

- Verify, approve and facilitate, as warranted, the organizations adoption and periodic review of a compliance plan that encompasses all required elements for the organization's Medicaid business, including overseeing the EOCCO's fraud, waste, and abuse prevention program;
- Review EOCCO's quarterly appeals and grievance log and grievance system analysis;
- Ensure that the organization's compliance activities are supported by adequate staff and other resources;
- Conduct periodic reviews of operational compliance metrics; Receive and direct the organization's response(s) to regular and ad hoc reports from the Compliance and Quality Committees and the Compliance Officer; and
- Take other such actions as are consistent with its purpose.

Meetings are held not less frequently than once a quarter

IV. Related Policies & Procedures, Forms and References

2007 Federal Sentencing Guidelines - §8B2.1(b)(3)

V.

New P & P /Change / Revision and Rationale	Final Review/Approval	Approval Date	Effective Date of Policy/Change
New policy to be included in FWA Handbook per 2020 CCO contract	EOCCO Quality Improvement Committee	03/18/2020	01/01/2020
Changes made due to 2022 contract changes	EOCCO Policy Subcommittee	12/16/2021	01/01/2022
Removed Ann Ford	EOCCO Policy Subcommittee	1/23/2023	01/01/2023
Added Karn Cady	EOCCO Policy Subcommittee	9/25/2023	01/01/2024

VI. Affected Departments:

All departments and subcontractors that are involved in the provision of administrative or health care services to EOCCO members.

EASTERN OREGON COORDINATED CARE ORGANIZATION		**Policy & Procedure**			
Company:	EOCCO	**Department Name:**		Compliance	
Subject:	Compliance Officer Designation and Program Oversight				
P & P Original Effective Date:	01/01/2020	**P &P Origination Date:**	01/01/2020	**P & P Published Date:**	01/01/2023
P & P Revision Effective Date:		**P & P Revision Published Date:**		01/01/2024	
Reference Number:		**Next Annual Review Date:**		9/1/2024	
Product (check all boxes applicable to this policy) ☒Dental ☒ Medical ☒ Pharmacy ☒ Behavioral Health					

I. Policy Statement and Purpose

The EOCCO board of directors will appoint a compliance officer who has operational responsibility for the development and effective implementation of an ethics and compliance program and Fraud, Waste and abuse Prevention Plan that meets the requirements articulated in the Health Plan Services Contract with the Oregon Health Authority. EOCCO is comitted the prevention of FWA and will comply with all applicable laws, including without limitation the State's False Claims Act and the Federal False Claims Act.

II. Definitions

N/A

III. Procedures

A. The compliance officer will be appointed by the EOCCO board of directors. EOCCO's Chief Compliance Officer is Nick Gross, 601 SW 2nd Avenue, Portland Oregon 97204, 503952-5033.

B. The compliance officer reports directly to the EOCCO chief executive officer and the board of directors.

C. The compliance officer is responsible for developing and implementing the written policies and procedures (FWA Handbook) set forth in paragraph b, section 11 of Exhibit B, Part 9, Fraud, Waste and Abuse. In addtion, the compliance offcer is responsbile for creating the Annual FWA Prevention Plan as described in section 12 of Exhibit B, Part 9. EOCCO will provide its FWA Handbook to all staff and post on its member and provider websites. At minimum EOCCO will include in its Member Handbook, the following related to FWA:

a) A statement or narrative that articulates contractor's commitment to:
   i. Prevent FWA

ii. Comply with all applicable Laws, including, without limitation, the State's False Claims Act and the Federal False Claims Act;

b) Examples of Fraud, Waste, and Abuse;

c) Where and how to report Fraud, Waste, and Abuse; and

d) A member's right to report FWA anonymously and to be protected under the applicable Whistleblower laws.

The compliance officer is responsible for ensuring EOCCO is committed to complying with the terms and conditions in sections 11, Exhibit B, Part 9 of the contract and all other applicable State and Federal laws. EOCCO has created a Special Investigations Unit (SIU) that is dediciated to, and responsible for, the implementation of the Annual FWA Prevention Plan and related FWA activities. Additionally, the SIU:

a) 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.

b) Demonstrates continuous work towards increasing the qualifications of its employees.

c) EOCCO SIU investigators must meet mandatory core and specialized training program requirements for such employees.

d) The team will 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.

e) 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.

The EOCCO SIU team consists of the SIU Supervisor and 3 SIU Investigators. The Supervisor of the EOCCO SIU is designated as the professional employee reporting directly to the Compliance Officer. This SIU Supervsor is responsible for the triage and analysis of all referrals, allegations of fraud, waste and abuse investigations and proactive leads as well as monitoring and triaging complaints anonymously made through the fraud, waste, and abuse hotline. The SIU Supervisor is an Accredited Healthcare Fraud Investigator, which requires a minimum of 5 years health care fraud detection and investigation experience, an Emergency Medical Technician Paramedic, and a Financial Crimes Investigator. The SIU Supervisor and staff have access to resources that may include Nurses and Medical Directors to aid in clinical decisions.

All SIU Investigators are proficient in Tableau, Excel, SAS, Query Configuration, HCFS Data Mining, Risk Evaluation, Medical Coding, Medical Documentation, Medical Claims Processing. Continuing education is obtained from participation in programs offered by National Healthcare Anti-Fraud Association including their four-day annual training conference. Training and sharing seminars offered by Healthcare Fraud Prevention Partnership. AAPC's webinars, workshops and annual training conference focused on medical coding, documentation, AMA guidelines, and medical coding changes.

All SIU personnel are required to hold and maintain at minimum a Certified Professional Coder credential earned through the AAPC (American Academy of Professional Coders). All SIU staff are required to participate in educational organizations such as the National Health Care Anti-Fraud Association (NHCAA), Healthcare Fraud Prevention Program (HFPP), AAPC and other credible continuing education sources. The current SIU Supervisor is an Accredited Healthcare Fraud Investigator, credentialed through NHCAA. The SIU Supervisor also holds dual coding credentials, Certified Professional Coder, and Certified Professional Coder – Payer through AAPC.
All SIU personnel are required to earn at a minimum 18 continuing education units annually in the fields of medical coding, auditing, fraud, waste, and abuse investigation, analytics, data mining and related fields.

IV. Related Policies & Procedures, Forms and References

2007 Federal Sentencing Guidelines - §8B2.1(b)(3)

V. Revision Activity

New P & P /Change / Revision and Rationale	Final Review/Approval	Approval date	Effective Date of Policy/Change
New policy to be included in FWA Handbook per 2020 CCO contract	EOCCO Quality Improvement Committee	03/18/2020	01/01/2020
Changes made due to 2022 contract changes	EOCCO Policy Subcommittee	12/16/2021	01/01/2022
Added Compliance Officer conctact information	EOCCO Policy Subcommittee	1/23/2023	01/01/2023
Annual review no changes	EOCCO Policy Subcommittee	9/25/2023	01/01/2024

VI. Affected Departments:

All departments and subcontractors that are involved in the provision of administrative or health care services to EOCCO members.

EASTERN OREGON COORDINATED CARE ORGANIZATION		**Policy & Procedure**			
Company:	EOCCO	**Department Name:**		Compliance	
Subject:	EOCCO Disciplinary Action for Compliance Policy				
P & P Original Effective Date:	01/01/2020	**P &P Origination Date:**	01/01/2020	**P & P Published Date:**	01/01/2023
P & P Revision Effective Date:		**P & P Revision Published Date:**		01/01/2024	
Reference Number:		**Next Annual Review Date:**		9/1/2024	
Product (check all boxes applicable to this policy) ☒Dental ☒ Medical ☒ Pharmacy ☒ Behavioral Health					

I. Policy Statement and Purpose

A. EOCCO, its delegates and other subcontractors will respond promptly to allegations of illegal for unethical conduct and take appropriate disciplinary action against employees or subcontractors who have violated fraud, waste and abuse policies or federal and state regulations addressing the privacy and security of member health information.

B. Workforce members will be given consistent, fair, clear and constructive means to correct problems regarding a lack of compliance.

C. Disciplinary action will provide a progression of steps designed to:
   1. Eliminate surprise to the employee.
   2. Emphasize the seriousness of the problem.
   3. Clarify the problem and corrective action required.
   4. Determine if the employee has the willingness and ability to correct the problem.

D. Corrective action, if necessary, will be taken in a timely, objective manner.

E. The termination authority for the position of EOCCO chief executive officer and corporate compliance officer shall be the board of directors.

F. This policy does not alter the fact that all employment in Oregon is “at-will,” which means that both the employee and the employer reserve the right to terminate the employment relationship at any time, for any lawful reason.

G. Disciplinary guidelines will be published in the employee handbooks for EOCCO, its delegates and other subcontractors.

II. Definitions

N/A

III. Procedure

A. Discipline will usually, but not always, be issued in a progressive manner. The nature of the infraction as well as other circumstances, (potentially including, but not limited to, the employee's past conduct), will be considered when determining the appropriate level of discipline. Situations may arise that require the discipline or discharge of an employee without benefit of the progressive disciplinary action. Levels may include the following:
   1. Oral warning
   2. Written warning
   3. Final warning
   4. Suspension, and/or
   5. Termination.

B. Each situation requiring disciplinary action will be addressed individually and nothing in this policy should be construed as a promise of specific treatment in a given situation.

IV. Related Policies & Procedures, Forms and References

§8B2.1.(6)(B)

V. Revision Activity

New P & P /Change / Revision and Rationale	Final Review/Approval	Approval Date	Effective Date of Policy/Change
New policy to be included in FWA Handbook per 2020 CCO contract	EOCCO Quality Improvement Committee	03/18/2020	01/01/2020
Annual Review no changes	EOCCO Policy Subcommittee	12/16/2021	01/01/2022
Annual Review no changes. OHA approval rec'd 11/2022	EOCCO Policy Subcommittee	1/23/2023	01/01/2023
Annual Review no changes.	EOCCO Policy Subcommittee	9/25/2023	01/01/2024

VI. Affected Departments:

All departments and subcontractors that are involved in the provision of administrative or health care services to EOCCO members.

eocco EASTERN OREGON COORDINATED CARE ORGANIZATION		**Policy & Procedure**			
Company:	EOCCO	**Department Name:**		Compliance	
Subject:	Effective Lines of Communication				
P & P Original Effective Date:	01/01/2020	**P &P Origination Date:**	01/01/2020	**P & P Published Date:**	01/01/2023
P & P Revision Effective Date:		**P & P Revision Published Date:**		01/01/2024	
Reference Number:		**Next Annual Review Date:**		9/1/2024	
Product (check all boxes applicable to this policy) ☒Dental ☒ Medical ☒ Pharmacy ☒ Behavioral Health					

I. Policy Statement and Purpose

A. EOCCO and its compliance officers, its delegates and subcontractors will maintain effective lines of communication between their compliance offices and other members of their workforce. Systems are in place that are designed to maintain effective lines of communication between the EOCCO compliance officer and its workforce and subcontractors. Steps are also taken to effectively communicate, periodically and in a practical manner the Code of Conduct, policies and procedures contained in this FWA HAndbook to the board of directors, high-level personnel EOCCO workforce members, and Subcontractors of EOCCO.

Communications with workers and subcontractors 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.

B. Examples of the ways that this communication may take place are:
1. Email
2. Staff meetings
3. Personal meetings with workforce members
4. Newsletters
5. PowerPoint presentations to affected departments/personnel
6. EOCCO Quality Improvement committee
7. Navex confidential compliance hotline

II. Definitions

N/A

III. Procedure

N/A

IV. Related Policies & Procedures, Forms and References

§8B2.1.(5)(C)

V. Revision Activity

New P & P /Change / Revision and Rationale	Final Review/Approval	Approval Date	Effective Date of Policy/Change
New policy to be included in FWA Handbook per 2020 CCO contract	EOCCO Quality Improvement Committee	03/18/2020	01/01/2020
Annual review no changes	EOCCO Policy Subcommittee	12/16/2021	01/01/2022
Annual Review no changes. OHA approval rec'd 11/2022	EOCCO Policy Subcommittee	1/23/2023	01/01/2023
Annual Review no changes.	EOCCO Policy Subcommittee	9/25/2023	01/01/2024

VI. Affected Departments:

All departments and subcontractors that are involved in the provision of administrative or health care services to EOCCO members.

EASTERN OREGON COORDINATED CARE ORGANIZATION		**Policy & Procedure**			
Company:	EOCCO	**Department Name:**		Compliance	
Subject:	Exclusion Screening				
P & P Original Effective Date:	01/01/200	**P &P Origination Date:**	01/01/2020	**P & P Published Date:**	01/01/2023
P & P Revision Effective Date:		**P & P Revision Published Date:**		01/01/2024	
Reference Number:		**Next Annual Review Date:**		9/1/2024	
Product (check all boxes applicable to this policy) ☒Dental ☒ Medical ☒ Pharmacy ☒ Behavioral Health					

I. Policy Statement and Purpose

A. EOCCO will take steps to ensure that Medicaid payment is not made for items or services furnished or prescribed by a participating provider, employee, subcontractor or board member excluded by the DHHS OIG List of Excluded Individuals and Entities (LEIE) or System for Award Management (SAM).

B. Each EOCCO and its subcontractors will conduct reviews of the LEIE and SAM exclusion lists.

C. LEIE/SAM exclusion checks for EOCCO medical, behavioral health and oral health providers are conducted by EOCCO representatives. Moda, GOBHI, ODS Community Dental, and Advantage Dental are responsible for screening their own employees, participating providers, subcontractors and board members.

II. Definitions

DHHS - is the Department of Health and Human Services.

OIG - is Office of Inspector General

Subcontractor - is any individual, partner, entity, facility or organization that has entered into a subcontract or administrative services agreement with EOCCO, or one of it's partner organizations, for any portion of work under EOCCO's contract with OHA.

Participating Provider - is any practitioner that provides medical, behavioral health or dental services to EOCCO members

III. Procedures

A. Employees - New Hire

1. Prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, or governing body member, each partner organization will review the LEIE and SAM.
2. If an individual is identified on either the LEIE list or the SAM, appropriate corrective action will be takenwith respect to such screened individuals including, termination of employment.
3. The results of these screenings will be stored by year and be accessed as needed.
4. Records of such screens will be reviewed annually.

B. Providers - New
1. Contracted medical, behavioral health and oral health providers will be screened for exclusion by an EOCCO representative as part of the initial credentialing process.
2. If a provider is identified on either the LEIE or SAM, EOCCO will not pursue a contractual relationship with that provider.
3. 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 on the excluded lists to include the LEIE and the EPLS. Reporting requirements can be met by providing such information to OHA's Provider Enrollment Unit via Administrative Notice.
4. The results of these screenings shall be stored by year and be accessed as needed.
5. EOCCO will provide 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.
6. Partner organizations will report any providers, identified during the credentialing process, who are on the excluded lists of the LEIE and SAM, to the following:
    a. Department of Health and Human Services
    b. Office of Inspector General
    c. Oregon Health Authoriry Program Integrity Audit Unit
    d. The EOCCO compliance officer
7. Oregon Health Authority (OHA) conducts site visits for provider types designated as 'moderate'. Provider types designated as 'high' risk must be actively enrolled in Medicaid and OHA relies on Medicaid site visit and fingerprint background check screening for these provider types. EOCCO will not enroll a provider type classified as 'moderate' or 'high' risk without OHA or CMS enrollment.

C. Monthly Screening
1. EOCCO, its subcontractors and participating providers will review the LEIE and the SAM on a monthly basis to ensure that employees, temporary employees, volunteers, consultants, governing body members, subcontractors and participating providers are not excluded or have become excluded from participation in federal programs.
2. If a screened individual is identified on either the LEIE list or the SAM, EOCCO and its its subcontractors and participating providers will take appropriate corrective action with respect to such screened individual, including termination of employment, removal from the board of directors, termination of any contractual relationship, or similar action consistent with the relationship between the parties.
3. 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 monthly screening process, who are on the excluded lists to include the LEIE and the EPLS.
4. Screening results shall be stored by month and can be accessed as needed.
5. All EOCCO subcontractors and participating providerare required to attest, on a yearly basis, that all employees, temporary employees, volunteers, consultants and governing body members have not been excluded from participation in federal programs and are screened for exclusion on a monthly basis.
6. This activity is monitored as part of the annual compliance oversight audit.

7. Partner organizations shall report any providers, identified during the monthly screening process, who are on the excluded lists to include the LEIE and SAM, to the following:
    a. Department of Health and Human Services
    b. Office of Inspector General
    c. Oregon Health Authoriry Program Integrity Audit Unit
    d. The EOCCO compliance officer

IV. Related Policies & Procedures, Forms and References

2007 Federal Sentencing Guidelines - §8B2.1(b)(3)

V. Revision Activity

New P & P /Change / Revision and Rationale	Final Review/Approval	Approval date	Effective Date of Policy/Change
New policy to be included in FWA Handbook per 2020 CCO contract	EOCCO Quality Improvement Committee	03/18/2020	01/01/2020
Changes made due to 2022 contract changes	EOCCO Policy Subcommittee	12/16/2021	01/01/2022
Annual Review no changes. OHA approval rec'd 11/2022	EOCCO Policy Subcommittee	1/23/2023	01/01/2023
Annual Review no changes.	EOCCO Policy Subcommittee	9/25/2023	01/01/2024

VI. Affected Departments:

All departments and subcontractors that are involved in the provision of administrative or health care services to EOCCO members.

EASTERN OREGON COORDINATED CARE ORGANIZATION		**Policy & Procedure**			
Company:	EOCCO	**Department Name:**		Compliance	
Subject:	Reporting Changes in Enrollee or Provider Circumstance				
P & P Original Effective Date:	01/01/2020	**P &P Origination Date:**	01/01/2020	**P & P Published Date:**	01/01/2023
P & P Revision Effective Date:		**P & P Revision Published Date:**		01/01/2024	
Reference Number:		**Next Annual Review Date:**		9/1/2024	
Product (check all boxes applicable to this policy) ☒Dental ☒ Medical ☒ Pharmacy ☒ Behavioral Health					

I. Policy Statement and Purpose

EOCCO will notify OHA regardless of whether EOCCO or a subcontractor is reporting the change, 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. EOCCO will provide 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.

II. Definitions

N/A

III. Procedure

A. Notification of a Change in Provider's Circumstance:

a. EOCCO will notify OHA when it receives information about a change in a network provider's or subcontractor circumstances that may affect the network provider's or subcontractor's eligibility to provide services on behalf of EOCCO, including the termination of the provider agreement.
b. EOCCO will provide Administrative Notice to OHA within thirty (30) days of receipt of such information regardless of whether CCO or a delegate is reporting the change to OHA.
c. 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)).

d.

B. Notification of a Change in Enrollee's Circumstances:

a. EOCCO will promptly notify OHA when it 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

b. In these instances EOCCO staff will send an email to Oregon.benefits@dhsoha.state.or.us notifying them of the change in circumstance.

IV. Related Policies & Procedures, Forms and References

V. Revision Activity

New P & P /Change / Revision and Rationale	Final Review/Approval	Approval date	Effective Date of Policy/Change
New policy to be included in FWA Handbook per 2020 CCO contract. Created after feedback from initial submission. Policy will need to be approved by QIC after OHA approval			
Changes made due to 2022 contract changes	EOCCO Policy Subcommittee	12/16/2021	01/01/2022
Annual Review no changes. OHA approval rec'd 11/2022	EOCCO Policy Subcommittee	1/23/2023	01/01/2023
Annual Review no changes.	EOCCO Policy Subcommittee	9/25/2023	01/01/2024

VI. Affected Departments:

All departments and subcontractors that are involved in the provision of administrative or health care services to EOCCO members.

eocco EASTERN OREGON COORDINATED CARE ORGANIZATION		**Policy & Procedure**			
Company:	EOCCO	**Department Name:**		Compliance	
Subject:	Reporting Fraud Waste and Abuse				
P & P Original Effective Date:	01/01/2020	**P &P Origination Date:**	01/01/2020	**P & P Published Date:**	01/01/2023
P & P Revision Effective Date:		**P & P Revision Published Date:**		01/01/2024	
Reference Number:		**Next Annual Review Date:**		9/1/2024	
Product (check all boxes applicable to this policy) ☒Dental ☒ Medical ☒ Pharmacy ☒ Behavioral Health					

I. Policy Statement and Purpose

A. EOCCO will have and publicize a system, which may include mechanisms that allow for anonymity or confidentiality, whereby the organization's workforce may report or seek guidance regarding potential fraud, waste or abuse or actual criminal conduct without fear of retaliation.

B. Role of the False Claims Law in Preventing Fraud, Waste, and Abuse

1. The Centers for Medicare & Medicaid Services (CMS) defines "fraud" as the intentional deception or misrepresentation that an individual knows to be false (or does not believe to be true) and makes, knowing that the deception could result in an unauthorized benefit to himself or another person. CMS defines "abuse" as provider incidents or practices that are inconsistent with sound medical practice and/or that might result in unnecessary costs, improper payment, or payment for services that are medically unnecessary or fail to meet professionally recognized standards of care.
2. Federally enacted criminal and civil laws allow criminal, civil and administrative penalties for submitting false or fraudulent claims for payment or approval, to federal or state governments or to private payers. Under these laws, government authorities have broad power to investigate and prosecute potentially fraudulent activities; and the laws include anti-retaliation provisions for individuals who make good faith reports of waste, fraud and abuse.

C. Federal Civil False Claims Act

1. The Civil False Claims Act (31 U.S.C. §3729 *et seq.*) imposes civil liability on any person who:
   a. Knowingly presents, or causes to be presented, a false or fraudulent claim, record or statement for payment or approval;
   b. Conspires to defraud the government by getting a false or fraudulent claim allowed or paid;
   c. Uses a false record or statement to avoid or decrease an obligation to pay the Government; or

d. Acts fraudulently in other ways the statute enumerates.

2. The Civil False Claims Act (FCA) defines the term "knowingly" to include a person who has actual knowledge of information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.
3. The term "claim" includes any request or demand for money or property if the United States Government provides any portion of that requested or demanded.
4. Potential civil liability under the FCA currently includes penalties of between five thousand five hundred and eleven thousand dollars per claim, treble damages, and the costs of any civil action brought to recover such penalties or damages.
5. The Attorney General of the United States is required to investigate FCA violations, and may bring a civil action against a person. Before filing suit, the Attorney General may issue an investigative demand requiring production of documents, written answers, or oral testimony.
6. The FCA also provides for actions by private persons (*qui tam* lawsuits) who can bring a civil action in the name of the government for a violation of the Act. Generally, such action may not be brought more than six years after the violation, but in no event more than ten. When the action is filed it remains under seal for at least sixty days. The United States Government may choose to intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing or settling the action. If the Government chooses not to intervene, the party who initiated the lawsuit has the right to conduct the action.
7. In the event the government proceeds with the lawsuit, the *qui tam* plaintiff may receive fifteen to twenty-five per cent of the proceeds of the action or settlement. A *qui tam* plaintiff who proceeds with the action without the government may receive twenty-five to thirty per cent of the amount recovered. In either case, the plaintiff also may receive an amount for reasonable expenses plus reasonable attorneys' fees and costs.
8. However, if the civil action is frivolous, clearly vexatious, or brought primarily for harassment, the plaintiff may have to pay fees and costs to the defendant. If the plaintiff planned or initiated the violation, the share of proceeds may be reduced and, if found guilty of a crime associated with the violation, no share will be awarded the plaintiff.
9. Examples of a False Claim
    a. Billing for items or services not performed
    b. Falsifying information in the resident's records
    c. Double billing for items or services

D. Whistleblower Protection

1. For employees, the Civil False Claims Act provides protection from retaliation. An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in terms and conditions of employment because of lawful acts to further an action under the FCA may bring an action in Federal District Court to seek reinstatement, two times the amount of back pay plus interest, and other costs, damages, and fees.

E. Federal Program Fraud Civil Remedies Act of 1986

1. The Program Fraud Civil Remedies Act of 1986 ("Administrative Remedies for False Claims and Statements" at 38 U.S.C. §3801 *et seq.*) establishes an administrative remedy against any person who presents or causes to be presented a claim or written statement that the person knows or has reason

to know is false, fictitious or fraudulent due to an assertion or omission to certain federal agencies (including the Department of Health and Human Services).

2. The term "knows or has reason to know" is defined in the Act as a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.
3. The term "claim" includes any request or demand for property or money, e.g., grants, loans, insurance or benefits, when the United States Government provides or will reimburse any portion of what is asked.
4. A federal department authority may investigate and, with the Attorney General's approval, commence proceedings if the claim is less than one hundred and fifty thousand dollars. A hearing must begin within six years from the date the claim is submitted. The Act allows civil monetary sanctions to be imposed, including penalties of five thousand five hundred dollars per claim and an assessment, in lieu of damages, of two time the amount of the original claim.

II. Definitions

N/A

III. Procedure

A. While EOCCO encourages member of its workforce to report suspected FWA to their supervisor or manager, EOCCO provides a toll-free hotline (855-801-2991) that allows EOCCO employees and others to report or seek guidance anonymously or confidentially regarding potential or actual criminal conduct without fear of retaliation. EOCCO members are provided information in their member handbook regarding definitions of fraud waste and abuse. EOCCO members are also provided an anonymous toll-free number (588-801-2991) to call to report instance of fraud, waste or abuse. EOCCO will maintain the privacy and anonymity of all reporting parties except where legally proscribed. . As described above, members that wish to bring forward Fraud, Waste and Abuse concerns anonymously may do so by using the EOCCO's toll free Hotline or may also submit anonymous allegation online via Ethics Point. 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.

B. When suspected or potential misconduct is reported, the allegations will be promptly investigated. Misconduct may be directly reported to the Compliance Department via phone or email. Additionally, employees, members, providers and subcontractors may also report misconduct via EOCCO's EthicsPoint compliance reporting website. Any allegation, whether reported through email, phone or EthicsPoint are recored and tracked in EthicsPoint. Responses are provided to responders as appropriate. In the event that an investigation reveals misconduct, corrective action will be immediately initiated. EOCCO will assure that reasonable steps are taken to respond to and prevent further misconduct, including the identification of any systemic shortcomings that compromise the deterrent effect of its Ethics and Compliance Program. If necessary, appropriate modifications will be made to the Program.

C. Examples and characteristics of Fraud Waste and Abuse Include, without limitation:

    a. Providers, other CCOs, or Subcontractors that intentionally or recklessly report Encounters or services that did not occur, or where products were not provided.
    b. Providers, other CCOs, or Subcontractors that intentionally or recklessly report overstated or up coded levels of service.

c. 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.
d. 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.
e. Providers, other CCOs, or Subcontractors that intentionally or recklessly make false statements about the credentials of persons rendering care to Members.
f. 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.
g. 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 Contractor, or Applicable Law.
h. 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 Contractor's payment to the Provider, in violation of Applicable Law.
i. Providers, other CCOs, or Subcontractors intentionally or recklessly submitted a claim for payment when such party knew the claim: (i) had already been paid by OHA or Contractor, (ii) had already been paid by another source.
j. Any case of theft, embezzlement or misappropriation of Title XIX or Title XXI program money.
k. Any practice that is inconsistent with sound fiscal, business, or medical practices, and which: (i) results in unnecessary costs, (ii) results in reimbursement for services that are not medically necessary, or (iii) fails to meet professionally recognized standards for health care.
l. Evidence of corruption in the Enrollment and Disenrollment process, including efforts of Contractor employees, State employees, other CCOs, or Subcontractors to skew the risk of unhealthy Member or potential Members toward or away from Contractor or any other CCO.
m. Attempts by any individual, including Contractor's employees, Providers, Subcontractors, other CCOs, Contractor, 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.

D. Reporting Fraud and Abuse
1. EOCCO will promptly refer all suspected cases of fraud, waste and abuse, including fraud by employees, participating providers, members and subcontractors or any other third parties to the Medicaid Fraud Control Unit (MFCU) and the OHA Office of Program Integrity (OPI).
2. Reporting will be made promptly but in no event more than seven (7) days after EOCCO is initially made aware of the suspicious case.
3. If EOCCO is made aware of a credible allegation of fraud by the MFCU, or of a pending investigation against a provider EOCCO, upon notification of an investigation by MFCU, will suspend payments to the provider unless MFCU determines there is good cause not to suspend payments or to suspend payments in part.
4. EOCCO 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. In the event that EOCCO reports suspected fraud, or learns of an MFCU or OPI, EOCCO will not notify or otherwise advise its subcontractors of the investigation so as not to

compromise the investigation.

5. Using the FWA Report Template (located 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 PI Audits performed by EOCCO and its subcontactors. The Annual FWA Audit Report and FWA Referrals and Investigation Report are due January 31 of each year 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 Audit Report and Referral and Investigation Report is due thirty (30) days following the end of each quarter and will be provided to OHA via Administrative Notice. For both the Quarterly and Annual FWA Audit Reports, EOCCO will report all PI Audits opened, in-process and closed during the reporting period. EOCCO will also provide to OHA, with Quarterly FWA Report, a copy of the final PI Audit report for each PI Audit identified in the FWA Audit Report as closed during the reporting period. Additionally, both reports will include all of EOCCO's open, ongoing and closed preliminary intestigations or suspected and credible cases.

6. Using the FWA Report Template, EOCCO will provide provide to OHA, via Administrative Notice, an annual summary report of Referrals, and cases investigated. The annual FWA Referrals & Investigations Report will be provided to OHA promptly after January 1 of each Contract Year following the reporting year but in no event later than January 31st.

7. EOCCO will report, regardless of its own suspicions or lack thereof, to the MFCU an incident with any of the characteristics listed in Section III (C) above. All reporting must be made as set forth below in this policy.

8. Subject to 42 C.F.R. §455.23, in the event OHA determines that a credible allegation of Fraud has been made against EOCCO, OHA will have the right to suspend, in whole or in part, payments made to EOCCO. In the event OHA determines that a credible allegation of Fraud has been made against EOCCO's Subcontractors, OHA will also have the right to direct EOCCO 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. until either OHA, or the prosecuting authorites determine there is insufficient evidence of fraud, or legal proceedings related to alleged fraud are completed.OHA has the right to forgo suspension and continue making Payments, or refrain from directing EOCCO 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). Thus including performing check holds, withholding payments, restriciting future enrollment and payments to Subcontractors. In the event OHA determines a credible allegation of Fraud has been made against a Subcontractor, EOCC will cooperate with OHA to determine, in accordance with the criteria set forth in 42 C.F.R. §455.23, whether sums otherwise payable by Contractor to such Subcontractor, must be suspended or whether good cause exists not to suspend such payments.

9. Medicaid fraud or abuse by a provider 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)
https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx

10. Suspected Medicaid fraud or abuse by a Member will be promptly reported to the DHS/OHA Fraud Investigation Unit. Such reporting may be made by mail, phone, or facsimile transmission using the following contact information:

    DHS 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

11. EOCCO will include the above contact information for MFCU, OPI DHS/OHA Fraud Investigation in its FWA Prevention Handbook and its Member Handbook. Additionally, the following relating to FWA will be included in the Member Handbook:
    a) A statement or narrative that articulates contractor's commitment to:
        ii. Prevent FWA
        iii. Comply with all applicable Laws, including, without limitation, the State's False Claims Act and the Federal False Claims Act;
    b) Examples of Fraud, Waste, and Abuse;
    c) Where and how to report Fraud, Waste, and Abuse; and
    d) Adescription of the process for members to report FWA anonymously and to be protected under the applicable Whistleblower laws.

13. EOCCO requires all subcontractors to comply with this policy and perform all obligations, terms and conditions as EOCCO as set forthg in Ex B, Part 9. Additionally, all subcontrators will be provided with the EOCCO FWA Handbook.

IV. Related Policies & Procedures, Forms and References

Federal Sentencing Guidelines - §8B2.1(b)(5)(C)

V. Revision Activity

New P & P /Change / Revision and Rationale	Final Review/Approval	Approval date	Effective Date of Policy/Change
New policy to be included in FWA Handbook per 2020 CCO contract	EOCCO Quality Improvement Committee	03/18/2020	01/01/2020
Changes made due to 2022 contract changes	EOCCO Policy Subcommittee	12/16/2021	01/01/2022
Added Annual Referral and Investigations Report to Sections III, D, 6	EOCCO Policy Subcommittee	01/23/2023	01/01/2023
Added language to sections III-B and D 1,5 and 8 due to OHA annual feedback	EOCCO Policy Subcommittee	09/25/2023	01/01/2024

VI. Affected Departments:

All departments and subcontractors that are involved in the provision of administrative or health care services to EOCCO members.

EASTERN OREGON COORDINATED CARE ORGANIZATION		**Policy & Procedure**			
Company:	EOCCO	**Department Name:**		Compliance	
Subject:	Reporting Misconduct				
P & P Original Effective Date:	01/01/2020	**P &P Origination Date:**	01/01/2020	**P & P Published Date:**	01/01/2023
P & P Revision Effective Date:		**P & P Revision Published Date:**		01/01/2024	
Reference Number:		**Next Annual Review Date:**		9/1/2024	
Product (check all boxes applicable to this policy) ☒Dental ☒ Medical ☒ Pharmacy ☒ Behavioral Health					

I. Policy Statement and Purpose

A. EOCCO will have and publicize a system, which may include mechanisms that allow for anonymity or confidentiality, whereby the organization's workforce may report or seek guidance regarding potential fraud, waste or abuse or actual criminal conduct without fear of retaliation.

B. Role of the False Claims Law in Preventing Fraud, Waste, and Abuse

1. The Centers for Medicare & Medicaid Services (CMS) defines "fraud" as the intentional deception or misrepresentation that an individual knows to be false (or does not believe to be true) and makes, knowing that the deception could result in an unauthorized benefit to himself or another person. CMS defines "abuse" as provider incidents or practices that are inconsistent with sound medical practice and/or that might result in unnecessary costs, improper payment, or payment for services that are medically unnecessary or fail to meet professionally recognized standards of care.
2. Federally enacted criminal and civil laws allow criminal, civil and administrative penalties for submitting false or fraudulent claims for payment or approval, to federal or state governments or to private payers. Under these laws, government authorities have broad power to investigate and prosecute potentially fraudulent activities; and the laws include anti-retaliation provisions for individuals who make good faith reports of waste, fraud, and abuse.

C. Federal Civil False Claims Act

1. The Civil False Claims Act (31 U.S.C. §3729 *et seq.*) imposes civil liability on any person who:
   a. Knowingly presents, or causes to be presented, a false or fraudulent claim, record or statement for payment or approval.
   b. Conspires to defraud the government by getting a false or fraudulent claim allowed or paid.
   c. Uses a false record or statement to avoid or decrease an obligation to pay the Government; or

d. Acts fraudulently in other ways the statute enumerates.

2. The Civil False Claims Act (FCA) defines the term "knowingly" to include a person who has actual knowledge of information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.
3. The term "claim" includes any request or demand for money or property if the United States Government provides any portion of that requested or demanded.
4. Potential civil liability under the FCA currently includes penalties of between five thousand five hundred and eleven thousand dollars per claim, treble damages, and the costs of any civil action brought to recover such penalties or damages.
5. The Attorney General of the United States is required to investigate FCA violations, and may bring a civil action against a person. Before filing suit, the Attorney General may issue an investigative demand requiring production of documents, written answers, or oral testimony.
6. The FCA also provides for actions by private persons (*qui tam* lawsuits) who can bring a civil action in the name of the government for a violation of the Act. Generally, such action may not be brought more than six years after the violation, but in no event more than ten. When the action is filed it remains under seal for at least sixty days. The United States Government may choose to intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing, or settling the action. If the Government chooses not to intervene, the party who initiated the lawsuit has the right to conduct the action.
7. In the event the government proceeds with the lawsuit, the *qui tam* plaintiff may receive fifteen to twenty-five per cent of the proceeds of the action or settlement. A *qui tam* plaintiff who proceeds with the action without the government may receive twenty-five to thirty per cent of the amount recovered. In either case, the plaintiff also may receive an amount for reasonable expenses plus reasonable attorneys' fees and costs.
8. However, if the civil action is frivolous, clearly vexatious, or brought primarily for harassment, the plaintiff may have to pay fees and costs to the defendant. If the plaintiff planned or initiated the violation, the share of proceeds may be reduced and, if found guilty of a crime associated with the violation, no share will be awarded the plaintiff.
9. Examples of a False Claim
    a. Billing for items or services not performed
    b. Falsifying information in the resident’s records
    c. Double billing for items or services

D. Whistleblower Protection

1. For employees, the Civil False Claims Act provides protection from retaliation. An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in terms and conditions of employment because of lawful acts to further an action under the FCA may bring an action in Federal District Court to seek reinstatement, two times the amount of back pay plus interest, and other costs, damages, and fees.

E. Federal Program Fraud Civil Remedies Act of 1986

1. The Program Fraud Civil Remedies Act of 1986 ("Administrative Remedies for False Claims and Statements" at 38 U.S.C. §3801 *et seq.*) establishes an administrative remedy against any person who presents or causes to be presented a claim or written statement that the person knows or has reason

to know is false, fictitious or fraudulent due to an assertion or omission to certain federal agencies (including the Department of Health and Human Services).

2. The term "knows or has reason to know" is defined in the Act as a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.
3. The term "claim" includes any request or demand for property or money, e.g., grants, loans, insurance, or benefits, when the United States Government provides or will reimburse any portion of what is asked.
4. A federal department authority may investigate and, with the Attorney General's approval, commence proceedings if the claim is less than one hundred and fifty thousand dollars. A hearing must begin within six years from the date the claim is submitted. The Act allows civil monetary sanctions to be imposed, including penalties of five thousand five hundred dollars per claim and an assessment, in lieu of damages, of two time the amount of the original claim.

II. Definitions

N/A

III. Procedure

A. While EOCCO encourages member of its workforce to report suspected misconduct to their supervisor or manager, EOCCO provides a toll-free hotline (1-800-399-7335) that allows EOCCO employees and others to report or seek guidance anonymously or confidentially regarding potential or actual criminal conduct 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.

B. When suspected or potential misconduct is reported, the allegations will be promptly investigated. In the event that an investigation reveals misconduct, corrective action will be immediately initiated. EOCCO will assure that reasonable steps are taken to respond to and prevent further misconduct, including the identification of any systemic shortcomings that compromise the deterrent effect of its Ethics and Compliance Program. If necessary, appropriate modifications will be made to the Program.

C. Reporting Fraud and Abuse

1. EOCCO will promptly refer all verified cases of fraud, waste and abuse, including fraud by employees and subcontractors or any other third parties to the Medicaid Fraud Control Unit (MFCU) and the OHA Program integrity Unit (PIAU).
2. Reporting will be made promptly but in no event more than seven (7) days after EOCCO is initially made aware of the suspicious case.
3. Reporting will be made promptly but in no event more than seven (7) days after EOCCO is initially made aware of the suspicious case.
4. If EOCCO is made aware of a credible allegation of fraud by the MFCU, or of a pending investigation against a providerEOCCO, upon notification of an investigation by MFCU, will suspend payments to the provider unless MFCU determines there is good cause not to suspend payments or to suspend payments in part.

- 5. EOCCO shall cooperate with the MFCU and OPI and their respecitive designess and the DHS Fraud Unit and any or all combination of those departments. EOCCO will allow them to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities as required to investigate an incident of fraud or abuse. In the event that EOCCO reports suspected fraud, or learns of an MFCU or PIAU, EOCCO will not notify

or otherwise advise its subcontractors of the investigation so as not to compromise the investigation. EOCCO will 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 will be provided without cost to MFCU, OPI, or their designees.

6. Medicaid fraud or abuse by a provider 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-FRAUD0l (888-372-8301)
https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx

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

8. Suspected Medicaid fraud or abuse by a Member will be promptly reported to the DHS/OHA Fraud Investigation Unit. Such reporting may be made by mail, phone, or facsimile transmission using the following contact information:

DHS Fraud Investigation
PO Box 14150
Salem, OR 97309
Hotline: 1-888-FRAUD0l (888-372-8301)
Fax: 503-373-1525 Attn: Hotline
https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx

9. EOCCO will include the above contact information for DHS/OHA Fraud Investigation in its FWA Prevention Handbook and its Member Handbook.

IV. Related Policies & Procedures, Forms and References

Federal Sentencing Guidelines - §8B2.1(b)(5)(C)

V. Revision Activity

New P & P /Change / Revision and Rationale	Final Review/Approval	Approval date	Effective Date of Policy/Change
Annual review no changes	EOCCO Policy Subcommittee	12/16/2021	01/01/2022
Annual Review no changes.	EOCCO Policy	1/23/2023	01/01/2023

OHA approval rec'd 11/2022	Subcommittee		
Annual review no changes	EOCCO Policy Subcommittee	9/25/2023	01/01/2024

VI. Affected Departments:

All departments and subcontractors that are involved in the provision of administrative or health care services to EOCCO members.

EASTERN OREGON COORDINATED CARE ORGANIZATION		**Policy & Procedure**			
Company:	EOCCO	**Department Name:**		Compliance	
Subject:	Retention and Reporting of Overpayments				
P & P Original Effective Date:	01/01/2020	**P &P Origination Date:**	01/01/2020	**P & P Published Date:**	01/01/2023
P & P Revision Effective Date:		**P & P Revision Published Date:**		01/01/2024	
Reference Number:		**Next Annual Review Date:**		9/1/2024	
Product (check all boxes applicable to this policy) ☒Dental ☒ Medical ☒ Pharmacy ☒ Behavioral Health					

I. Policy Statement and Purpose

EOCCO will self-report to OHA within sixty (60) days of its identification any overpayment it received from OHA under the Health Plan Services Contract or any other contract, agreement, or MOU entered into by EOCCO and OHA.

EOCCO will 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 EOCCO and regardless of whether such overpayment was the result of an fraud, waste, or abuse or accounting error. If identification of overpayment was the result of self-reporting to EOCCO by a provider, subcontractor, other third-party, EOCCO will report and return 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 EOCCO as a result of Program Integrity Audit or investigation, such overpayment will be reported to OHA promptly, but in no event more than seven (7) days after identifying such overpayment. If EOCCO suspects an overpayment identified during a PI audit or investigation is due to fraud, waste, or abuse, such overpayment will be reported in accordance with Sec. 17, Ex. B, Part 9 of the OHA Health Plan Services Contract. All such reports made by the provider, subcontractor, or other third-party must be made to EOCCO within 60 days and include a written statement identifying the reason(s) for the return of the excess payment.

EOCCO will report all overpayments identified or recovered, regardless of whether the overpayments were the result of self-reporting or the result of a routine or planned PI Audit or other review, on the quarterly and annual financial reports required under the Health Plan Services Contract.

A. OHA and EOCCO Program Integrity Audits of Network Providers

1. If OHA conducts a Program Integrity 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 shall have the right, at its discretion, to pursue recovery of the Overpayments made by EOCCO to the applicable Providers. OHA will provide EOCCO's Contract Administrator with Administrative Notice of its findings and its decision relating to means of and timeframe for recovery of any finding of Overpayment.

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

2. If EOCCO or its subcontractors conduct PI Audits 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.
3. In addition to reporting all identified and recovered overpayments made to providers, subcontractors, or other third parties EOCCO will also comply with all of the procedures for managing and otherwise processing the recovery of such overpayments as follows:
    a. EOCCO will adjust, void or replace, as appropriate, each encounter claim to reflect the valid ecounter claim once EOCCO has recovered overpayment within thirty (30) days of identifying such overpayment.
    b. 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 must be made in accordance with and made available to OHA and other parties in accordance with Ex. D, of the OHA Health Plan Services Contract.
    c. In the event that 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 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.
    d. Examples of Overpayment types that might be made to Providers, Subcontractors, or other third parties include, but are not limited to, the following:
        i. Payments for Non-Covered Services,
        ii. Payments in excess of the allowable amount for an identified covered service,
        iii. Errors and non-reimbursable expenditures in cost reports,
        iv. Duplicate payments, and
        v. Receipt of Medicaid payment when another payer had the primary responsibility for payment, and is not included in an automated TPL retroactive recovery process.
    e. EOCCO will not retain any overpayments made to any provider or any subcontractor that are recovered as a result of (i) claims brought under the State or federal False Claims Acts (ii) a judgment or settlement arising out of or related to litigation involving claims of fraud, or (iii) 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.
4. 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 PI 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.

B. OHA and EOCCO Program Integrity Audits of Network Providers

In addition to the procedures for reporting required under Exhibit B, Part 9, EOCC0 has developed and maintains a procedure for accurately reporting all Overpayments on its quarterly and annual Financial Reports as required under section 1, paragraph a., subparagraph (2),3, Exhibit L. EOCCO's Exhibit L Report will include all Overpayments, identified or recovered regardless of whether the Overpayments were the result of:

a) self-reporting under subparagraphs (15) and (16) of paragraph b. section 11, Exhibit B, Part 9; or
b) the result of a routine or planned auditPI Audit or other review.

II. Definitions

N/A

III. Procedures

N/A

IV. Related Policies & Procedures, Forms and References

V. Revision Activity

New P & P /Change / Revision and Rationale	Final Review/Approval	Approval date	Effective Date of Policy/Change
New policy to be included in FWA Handbook per 2020 CCO contract	EOCCO Quality Improvement Committee	03/18/2020	01/01/2020
Changes made due to 2022 contract changes	EOCCO Policy Subcommittee	12/16/2021	01/01/2022
Annual Review no changes. OHA approval rec'd 11/2022	EOCCO Policy Subcommittee	1/23/2023	01/01/2023
Added language to section I per OHA feedbacl	EOCCO Policy Subcommittee	9/25/2023	01/01/2024

VI. Affected Departments:

All departments and subcontractors that are involved in the provision of administrative or health care services to EOCCO members.

eocco EASTERN OREGON COORDINATED CARE ORGANIZATION	**Policy & Procedure**

Company:	EOCCO	**Department Name:**		Compliance	
Subject:	Workforce Training				
P & P Original Effective Date:	01/01/2020	**P &P Origination Date:**	01/01/2020	**P & P Published Date:**	01/01/2023
P & P Revision Effective Date:		**P & P Revision Published Date:**		01/01/2024	
Reference Number:		**Next Annual Review Date:**		9/1/2024	
Product (check all boxes applicable to this policy) ☒Dental ☒ Medical ☒ Pharmacy ☒ Behavioral Health					

I. Policy Statement and Purpose

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.

a) Such training and education includes, without limitation, the right to be protected as a whistleblower, persuant to Section 1902(a)(68) of the Social Security Acti for reporting any fraud, waste, or abuse.
b) EOCCO'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 Contractor's Medicaid FWA policies and procedures, including any time parameters required for compliance with Ex B, Part 9 of the Contract.
d) Additionally it includes 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.

II. Definitions

N/A

III. Procedure

A. New members of the EOCCO and subcontractor workforce will receive training on the code of conduct and the ethics and compliance program within 60 days of the initiation of their relationship with EOCCO.

B. EOCCO requires any Subcontractors to comply with and perform all of the same obligations, terms and conditions of Contract as set forth in Ex. B, Part 9. Such annual education and training includes material relating to, as set forth in 42 CFR §§438.608(b) and 438.214(d):
    a. The credentialing and enrollment of Providers and Subcontractors; and
    b. The prohibition of employing, Subcontracting or otherwise being Affiliated with (or any combination or all of the foregoing) sanctioned individuals.

C. All EOCCO staff receive annual compliance and FWA training. Attendance is mandatory for all staff including the compliance officer, senior management, and those responsible for credentialing providers and subcontractors. The new hire and annual FWA training cover the following:
    a. Definition and examples of FWA
    b. Understanding Federal and State FWA Laws
    c. Exclusion Provisions
    d. Credentialing and Enrollment of Providers and Subcontractors
    e. Detection, Prevention and Correction of FWA
    f. Key Indicators of FWA
    g. Reporting FWA
    h. Non-Retaliation/Whistleblower protection

D. Subcontractors shall be required to attest that they offer their own training that covers these topics. In the event EOCCO subcontractors do not offer equivalent training, EOCCO will require subcontractors to take EOCCO's FWA /compliance training module. As part of EOCCO's annual subcontractor review, subcontractors, that provide their own FWA training, will be required to submit FWA training materials that cover the topics above. The EOCCO Compliance team will ensure the training covers the topics described above.

E. Other methods of training the staff such as an EOCCO newsletter, periodic oral reminders at EOCCO staff meetings, Relias training modules, in-house videos, lunchtime presentations, and the use of office posters may also be used from time to time.

IV. Related Policies & Procedures, Forms and References

Federal Sentencing Guidelines §8B2.1.(b)(2) and §8B2.1.(b)(4)

V. Revision Activity

New P & P /Change / Revision and Rationale	Final Review/Approval	Approval date	Effective Date of Policy/Change
New policy to be included in FWA Handbook per 2020 CCO contract	EOCCO Quality Improvement Committee	03/18/2020	01/01/2020
Changes made due to 2022 contract changes	EOCCO Policy Subcommittee	12/16/2021	01/01/2022
Annual Review, no changes to policy. All feedback rec'd from OHA was related to traning itself.	EOCCO Policy Subcommittee	1/23/2023	01/01/2023
Added language to section D	EOCCO Policy	9/25/2023	01/01/2024

	Subcommittee		

VI. Affected Departments:

All departments and subcontractors that are involved in the provision of administrative or health care services to EOCCO members.

EASTERN OREGON COORDINATED CARE ORGANIZATION		**Policy & Procedure**			
Company:	EOCCO	**Department Name:**		Compliance	
Subject:	Auditing and Monitoring and Service Verfication				
P & P Original Effective Date:	01/01/2020	**P &P Origination Date:**	01/01/2020	**P & P Published Date:**	01/01/2023
P & P Revision Effective Date:		**P & P Revision Published Date:**		01/01/2024	
Reference Number:		**Next Annual Review Date:**		9/1/2024	
Product (check all boxes applicable to this policy) ☒Dental ☒ Medical ☒ Pharmacy ☒ Behavioral Health					

I. Policy Statement and Purpose

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.

II. Definitions

N/A

III. Procedure

A. Provider Audit:
   a. EOCCO will review a sample of participating provider health records on a quarterly basis to determine if what was billed to EOCCO matches the clinical record.
   b. If non-compliant practices are identified that result in documentation errors in the health records, a corrective action plan shall be developed and providers will be notified.
   c. EOCCO will re-audit a sample of records after an appropriate period of time to determine if the corrective action has been effective. If not, additional corrective action shall be taken and re-audited.
   d. If errors in documentation have resulted in inaccurate encounter data reporting or billing for services, those reports shall be corrected or the services shall be re-billed or refunded.

B. Service Verification: EOCCO will routinely verify whether services that have been represented to have been delivered by Participating Providers and Subcontractors were received by Members, to investigate incidents where services were not delivered or where Member paid out of pocket for services, and collect any associated Overpayments. Such verification of services must be made by:
   a. EOCCO will sample 1% of all paid claims on a quarterly basis.
   b. Based upon that sample EOCCO will send service verifcation letters to members asking them to verify they received the services billed.
   c. Members that do not recognize or did not receive services billed are asked to reply as such with self addressed, postage paid envelope.
   d. Once received, EOCCO staff will reach out to the provider in question and request that the provider send in the medical record for the date of service in question. EOCCO staff will review the medical records and compare to what was paid to the provider to ensure services were received or if an error or fraud occurred.
   e. If non-compliant practices are identified that result in documentation errors in the health records, a corrective action plan shall be developed and providers will be notified.
   f. If errors in documentation, suspected fraud, waste or abuse or other overpayments have resulted in inaccurate billing for services, those reports shall be corrected or the services shall be re-billed,refunded and/or referred to OPI and MFCU.

IV. Related Policies & Procedures, Forms and References

Federal Sentencing Guidelines §8B2.1.(5)(B)

V. Revision Activity

New P & P /Change / Revision and Rationale	Final Review/Approval	Approval date	Effective Date of Policy/Change
New policy to be included in FWA Handbook per 2020 CCO contract	EOCCO Quality Improvement Committee	03/18/2020	01/01/2020
Changes made due to 2022 contract changes	EOCCO Policy Subcommittee	12/16/2021	01/01/2022
Annual Review no changes. OHA approval rec'd 11/2022	EOCCO Policy Subcommittee	1/23/2023	01/01/2023
Annual Review no changes.	EOCCO Policy Subcommittee	9/25/2023	01/01/2024

VI. Affected Departments:

All departments and subcontractors that are involved in the provision of administrative or health care services to EOCCO members.