2024 Annual Workshop

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EOCCO Overview

- EOCCO is a community-governed organization that brings together physical, behavioral & dental providers to coordinate care for people on the Oregon Health Plan

- Our territory is made up of 12 eastern counties:
  - Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, & Wheeler

- We currently serve roughly 81,000 lives
  - Membership peaked 9/28 with 81,973 members

Redetermination Update

January 1, 2023

Dental Only Benefit

Includes Veteran's Dental and Compact of Free Association

July 1, 2023

Healthier Oregon Program Expansion

Coverage for all age groups

July 1, 2024

Basic Health Plan (BHP)

New Coverage: 138% to 200% of the FPL

July 2023 Enrollment		
Benefit Plan	**Total Membership**	**% of Membership**
Medicaid	71,270	87%
HOP	4,648	6%
Dental Only	5,466	7%
Total	**81,384**	**100%**

September 2024 Enrollment		
Benefit Plan	**Total Membership**	**% of Membership**
Medicaid	68,645	84%
HOP	6,820	8%
Dental only	4,697	6%
BHP	1,269	2%
Total	**81,431**	**100%**

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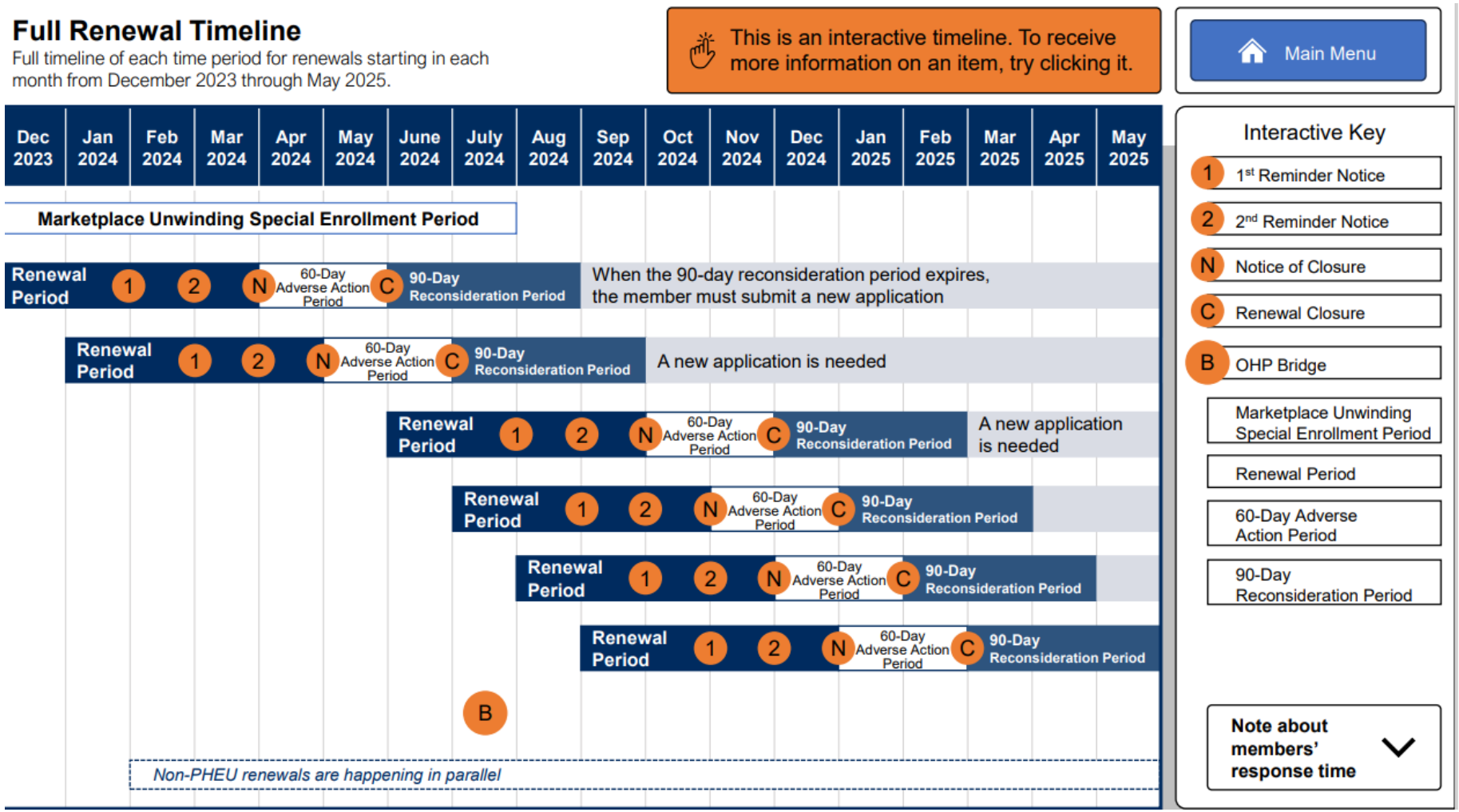
Medicaid Redetermination



Topics

- Eligibility & PCP updates
- Prioritized List of Covered Services
- Referral & Authorizations
- Claims
- Incentive Measures
- Behavioral Health Services
- Additional Benefits & Resources
- Policies
- Fraud, Waste & Abuse
- Looking Ahead
- Contacting EOCCO

Eligibility & PCP updates

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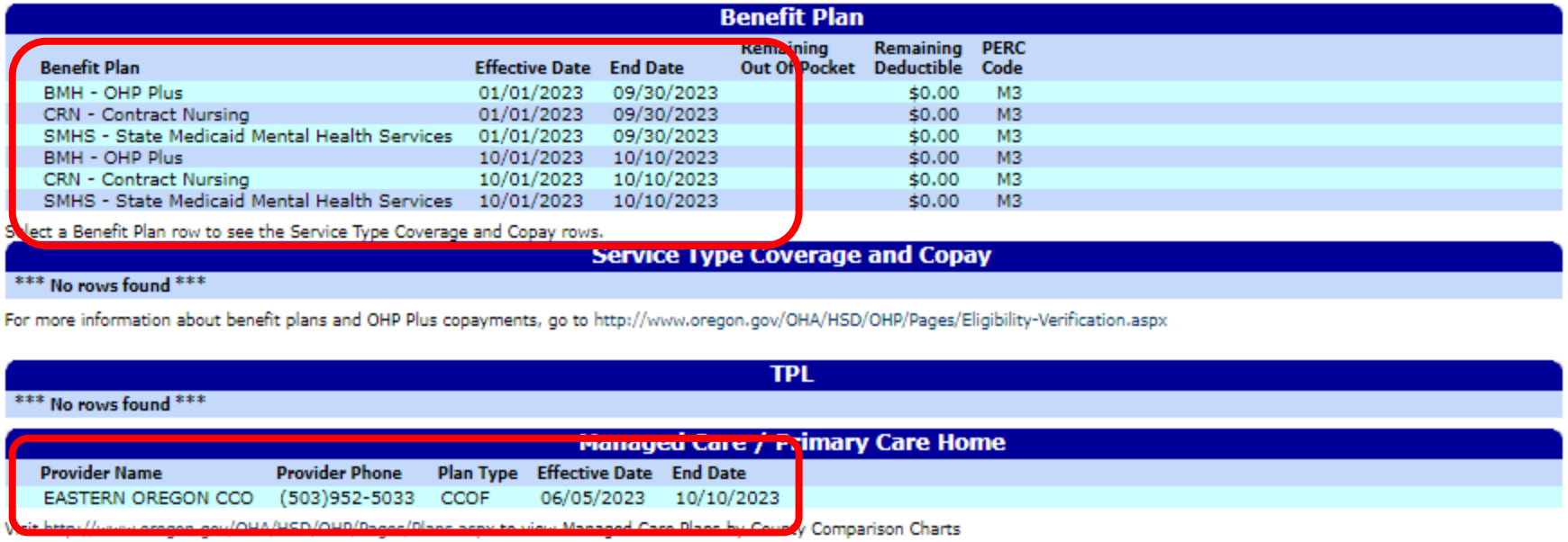
Verifying Eligibility

- In accordance with OAR 410-120-1140, providers are responsible to verify the following before rendering services:
  - Client eligibility
  - Benefit coverage

- ID cards do not guarantee client eligibility or benefit coverage



Benefit Plan

Benefit Plan	Effective Date	End Date	Remaining Out Of Pocket	Remaining Deductible	PERC Code
BMH - OHP Plus	01/01/2023	09/30/2023		$0.00	M3
CRN - Contract Nursing	01/01/2023	09/30/2023		$0.00	M3
SMHS - State Medicaid Mental Health Services	01/01/2023	09/30/2023		$0.00	M3
BMH - OHP Plus	10/01/2023	10/10/2023		$0.00	M3
CRN - Contract Nursing	10/01/2023	10/10/2023		$0.00	M3
SMHS - State Medicaid Mental Health Services	10/01/2023	10/10/2023		$0.00	M3

Select a Benefit Plan row to see the Service Type Coverage and Copay rows.

Service Type Coverage and Copay

*** No rows found ***

For more information about benefit plans and OHP Plus copayments, go to http://www.oregon.gov/OHA/HSD/OHP/Pages/Eligibility-Verification.aspx

TPL

*** No rows found ***

Managed Care / Primary Care Home

Provider Name	Provider Phone	Plan Type	Effective Date	End Date
EASTERN OREGON CCO	(503)952-5033	CCOF	06/05/2023	10/10/2023

Visit http://www.oregon.gov/OHA/HSD/OHP/Pages/Plans.aspx to view Managed Care Plans by County Comparison Charts

Who to Bill?

Plan Type Displayed	Who is responsible for payment?		
	Behavioral health	**Dental**	**Physical health**
CCO-A	CCO	CCO	CCO
CCO-B	CCO	OHA or DCO	CCO
CCO-E	CCO	OHA or DCO	OHA
CCO-F	OHA	CCO	OHA
CCO-G	CCO or MHO	CCO	OHA
None listed	OHA	OHA	OHA

PCP Assignments & Request

- A Primary Care Physician (PCP) assignment is required

- Requests can be made by member, member's family member, member's caseworker, or by practitioner on the member's behalf

- Members who are unassigned after 30 days of enrollment
  - Will be auto-assigned by EOCCO
  - Assignments is based on the county & city of the member's residence
  - Assignments are to the highest certified Patient Centered Primary Care Home (PCPCH), when available

- Online submission and physical forms can be found on EOCCO.com/providers/forms

Prioritized List of Covered Services

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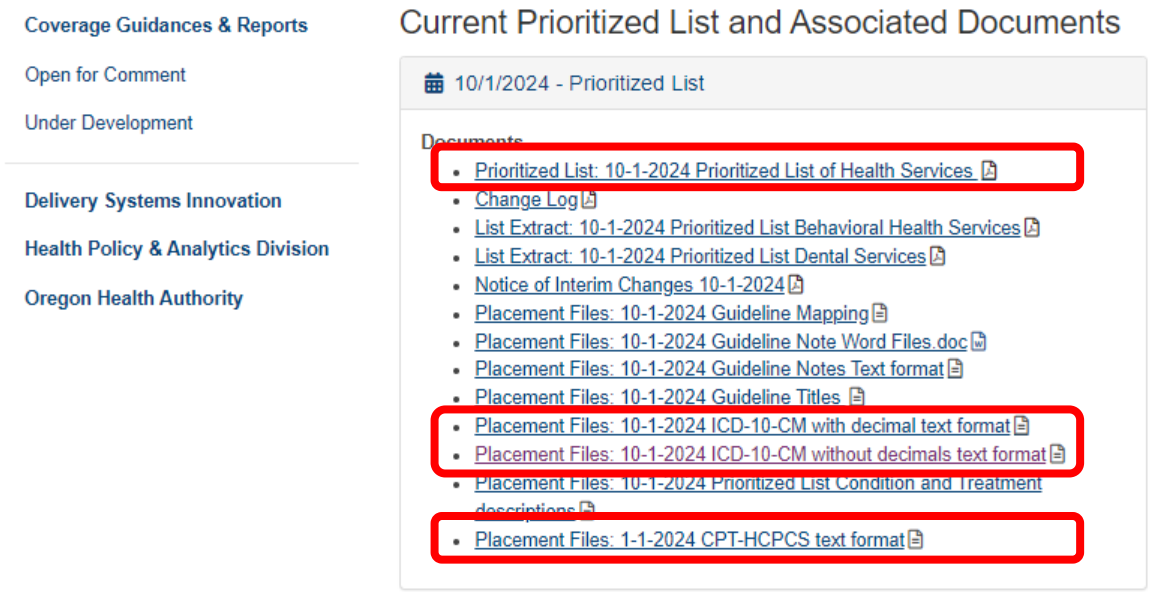
Prioritized List of Covered Services

- As of January 1, 2024:
  - Lines 1-469 are “Funded” or “Above the Line (ATL)”
  - Lines 470-654 are “Non-funded” or “Below the line (BTL)”
  - Codes that are not found on the prioritized list are called “Unlisted”

- List of covered services can be found
  - www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx



Prioritized List: Funded, Unfunded & Unlisted

- Diagnosis D03.70 falls on line 229 which is above-the-line (ATL)
- Diagnosis D16.00 falls on line 401 & 558 which is ATL & below-the-line (BTL)
- Diagnosis D17.0 falls on line 627 which is BTL

Line	ICD-10-CM	Line	ICD-10-CM	Line	ICD-10-CM	Line	ICD-10-CM
262	D02.22	242	D04.9	627	D11.7	401	D16.20
287	D02.3	191	D05.00	627	D11.9	558	D16.20
262	D02.4	191	D05.01	166	D12.0	401	D16.21
229	D03.0	191	D05.02	166	D12.1	558	D16.21
229	D03.10	191	D05.10	166	D12.2	401	D16.22
229	D03.111	191	D05.11	166	D12.3	558	D16.22
229	D03.112	191	D05.12	166	D12.4	401	D16.30
229	D03.121	191	D05.80	166	D12.5	558	D16.30
229	D03.122	191	D05.81	166	D12.6	401	D16.31
229	D03.20	191	D05.82	166	D12.7	558	D16.31
229	D03.21	191	D05.90	166	D12.8	401	D16.32
229	D03.22	191	D05.91	166	D12.9	558	D16.32
229	D03.30	191	D05.92	638	D13.0	401	D16.4
229	D03.39	25	D06.0	638	D13.1	558	D16.4
229	D03.4	25	D06.1	638	D13.2	401	D16.5
229	D03.51	25	D06.7	638	D13.30	558	D16.5
229	D03.52	25	D06.9	638	D13.39	401	D16.6
229	D03.59	208	D07.0	638	D13.4	558	D16.6
229	D03.60	286	D07.1	638	D13.5	401	D16.7
229	D03.61	286	D07.2	638	D13.6	558	D16.7
229	D03.62	286	D07.30	190	D13.7	401	D16.8
229	D03.70	286	D07.39	638	D13.9	558	D16.8
229	D03.71	258	D07.4	525	D14.0	401	D16.9
229	D03.72	329	D07.5	372	D14.1	558	D16.9
229	D03.8	258	D07.60	372	D14.2	627	D17.0
229	D03.9	258	D07.61	372	D14.30	627	D17.1
242	D04.0	258	D07.69	372	D14.31	627	D17.20
242	D04.10	271	D09.0	372	D14.32	627	D17.21
242	D04.111	214	D09.19	372	D14.4	627	D17.22
242	D04.112	112	D09.20	372	D15.0	627	D17.23
242	D04.121	112	D09.21	372	D15.1	627	D17.24
242	D04.122	112	D09.22	372	D15.2	627	D17.30
242	D04.20	259	D09.3	372	D15.7	627	D17.39
242	D04.21	259	D09.8	372	D15.9	627	D17.4
242	D04.22	627	D10.0	401	D16.00	627	D17.5
242	D04.30	627	D10.1	558	D16.00	627	D17.6
242	D04.39	627	D10.2	401	D16.01	511	D17.71
242	D04.4	627	D10.30	558	D16.01	627	D17.72
242	D04.5	627	D10.39	401	D16.02	401	D17.79
242	D04.60	627	D10.4	558	D16.02	558	D17.79
242	D04.61	627	D10.5	401	D16.10	638	D17.79
242	D04.62	627	D10.6	558	D16.10	627	D17.9
242	D04.70	627	D10.7	401	D16.11	627	D18.00
242	D04.71	627	D10.9	558	D16.11	321	D18.01
242	D04.72	287	D11.0	401	D16.12	627	D18.01
242	D04.8	627	D11.0	558	D16.12	125	D18.02

Prioritized List: Pairing

- CPT 15005 falls on lines 47, 57, 82, 86, 127, 181, 207, 229, 276, 285, 379, 424. ATL & pairs with DX D03.70
- CPT 17106 falls on lines 242, 276, 321, 401, 558, 625 & 627. ATL & BTL for DX D16.00 but only BTL for diagnosis D17.0

Line	Code	Line	Code	Line	Code	Line	Code
235	15003	127	15275	625	15877	387	17000
276	15003	181	15275	625	15878	452	17000
285	15003	379	15275	625	15879	508	17000
379	15003	57	15276	379	15920	522	17000
424	15003	127	15276	379	15922	554	17000
47	15004	181	15276	379	15931	588	17000
57	15004	379	15276	379	15933	603	17000
82	15004	57	15277	379	15934	613	17000
86	15004	127	15277	379	15935	625	17000
127	15004	181	15277	379	15936	627	17000
181	15004	379	15277	379	15937	242	17003
207	15004	57	15278	379	15940	276	17003
229	15004	127	15278	379	15941	387	17003
276	15004	181	15278	379	15944	508	17003
285	15004	379	15278	379	15945	554	17003
379	15004	191	15771	379	15946	588	17003
[illegible]	[illegible]	191	15772	379	15950	603	17003
47	15005	625	15780	379	15951	613	17003
57	15005	625	15781	379	15952	625	17003
82	15005	625	15782	379	15953	627	17003
86	15005	625	15783	379	15956	242	17004
127	15005	625	15786	379	15958	276	17004
181	15005	625	15787	57	16000	387	17004
207	15005	625	15788	181	16000	508	17004
229	15005	625	15789	605	16000	554	17004
276	15005	625	15792	57	16020	588	17004
285	15005	625	15793	127	16020	603	17004
379	15005	351	15822	181	16020	613	17004
424	15005	471	15822	605	16020	625	17004
[illegible]	[illegible]	351	15823	57	16025	[illegible]	[illegible]
127	15271	471	15823	127	16025	242	17106
181	15271	625	15830	181	16025	276	17106
379	15271	625	15832	605	16025	321	17106
57	15272	625	15833	57	16030	401	17106
127	15272	625	15834	127	16030	558	17106
181	15272	625	15835	181	16030	625	17106
379	15272	625	15836	605	16030	627	17106
57	15273	625	15837	57	16035	[illegible]	[illegible]
127	15273	625	15838	127	16035	276	17107
181	15273	625	15839	181	16035	321	17107
379	15273	485	15840	57	16036	401	17107
57	15274	485	15841	127	16036	558	17107
127	15274	485	15842	181	16036	625	17107
181	15274	71	15845	242	17000	627	17107
379	15274	207	15845	276	17000	242	17108
57	15275	625	15876	373	17000	276	17108

Referrals & Authorizations

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Referrals

- Effective for 180 days
  - Two visits for BTL
  - Four visits for ATL out-of-network
- Out-of-State Non-Contiguous
  - Service not available in the State of Oregon
  - Is Cost Effective
  - Recommended by an Oregon referring physician
- Required for
  - Services that are BTL, non-funded or unlisted
  - Out-of-network specialist & ancillary providers
- Not Required for
  - New patient E/M codes even if the diagnosis is BTL
  - Special Health Care Needs (SHCN) in or out-of-network
  - Behavioral health services
  - Family planning, routine OB care & prenatal care
  - Immunizations
  - Orthopedic providers
  - Routine vision
  - Tobacco cessation treatment & counseling
  - Urgent & emergent care

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Authorizations

- Submit authorization requests to EOCCO
  - Fax: 833-949-1886
  - Phone: 888-474-8540
  - Online via Moda's Benefit Tracker

- Standard request is the most common selection
  - Completed within 14 days of receipt

- Expedited request should only be selected when it would put the enrollee's life, health, or ability to regain maximum function in serious jeopardy
  - Completed in 72 hours

- Retro authorizations are allowed up to 90 days from the date of service

- Request are not required by primary, if primary covers the service

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Authorizations

- Prime Therapeutics Management
  - Formally Magellan RX
  - Reviews & authorizes select chemotherapy & specialty drugs
- eviCore
  - Reviews & authorizes most of our radiology, cardiology & advanced imaging request
  - Retro request up to 90 days from date of service

Authorizations

- Will not be approved if
  - All required documentation is not received
  - The provider is not active with HSD-DMAP
  - Retroactive requests received after 90 days from the date of service
  - A valid referral is not on file to a specialist (if required)
  - Smoking cessation & elective procedures Ancillary Guideline A4 is not followed prior to authorization submission

- More information and our prior authorization list can be found on www.eocco.com/providers/referral-auths There are multiple lists to be review
  - Injectable
  - Standard
  - Ages 21 and under
  - eviCore Advantage Imaging
  - eviCore Cardiology
  - Behavioral health covered/non-covered

Claims

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Claims

- Timely filing is 120 days from the date of service
  - Twelve months for corrected from the date of service for maternity & newborn related, COB, W/C, accident-related claims & OMAP denials for members having CCO coverage
- Payment is made via EFT/ERA or Zelis
- Medicaid is payer of last resort
  - We pay as primary for VFC
- Mail claims to
  - PO Box 40384
  - Portland, OR 97240
- Electronic Payer ID
  - 13350

Provider Refund Submission

- Providers who have identified a claim that has overpaid, can submit a refund submission form to initiate a review and adjustment/reprocessing request

- Forms are located; www.modahealth.com/pdfs/provider_refund_form.pdf

- When not to use this form
    - You are unsure if the claim was overpaid
    - You have already contacted EOCCO Customer Service &/or EOCCO Provider Relations about the overpayment

Below-the-Line

- Below-the-Line (BTL) services are not covered under the plan unless
  - The member is receiving care from their PCP/PCP Clinic
  - Member must be assigned at the time of service
  - There is an active, valid referral on file to a specialist
  - Urgent & emergency related services
  - Non-Emergent Medical Transport (NEMT)
  - Maternity related services
  - Community Health Worker (CHW) services
  - The member is covered under a primary plan and the services is covered by the plan
  - Valid authorization on file (if applicable)
  - The member is on a Special Healthcare Needs (SHCN) plan

Credentialing & Contracting

- Before a provider can be contracted with EOCCO or be added to an existing contract, a provider must be credentialed through Moda Health
    - All licensed independent practitioners need to be credentialed
    - Credentialing through Moda will credential for EOCCO & all lines of business for Moda Health
    - Process can take 90 days when a completed Oregon Credentialing Practitioner Application (OCPA) is received
    - Provider must be enrolled with Oregon Medicaid
    - Process is every 3 years

- Once credentialed, they can be added to an existing contract or begin contract negotiations with our contracting team if one is not already in place
    - Contracting date is credentialing date if a provider is being added to an existing contract

DMAP Enrollment

- All rendering & attending providers, prescribing physicians & pharmacies & all facilities must be actively registered with DMAP to get reimbursed for the services provided

- Redeterminations are every 3 years

- Complete a webapp submission form or return physical, completed forms to; ProviderDMAPApps@modahealth.com
    - 30-60 days to process once a completed application is received
    - We automatically adjust all claims denied for 84M back to enrollment date, if we process the enrollment

- More information can be found;
    - eocco.com/providers/becomeaprovider
    - oregon.gov/oha/hsd/ohp/pages/provider-enroll.aspx

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DMAP Enrollment

- Providers can verify via active enroll via MMIS
  - www.or-medicaid.gov/ProdPortal/Validate%20NPI/tabid/125/Default.aspx
  - If shows valid in MMIS but not with EOCCO then they will most likely will show up on next week's file as active

- Or through the "Weekly Provider Files" under "Tools for Health Plans"
  - www.oregon.gov/oha/HSD/OHP/Pages/Plan-Tools.aspx
  - Downloadable Zip file
  - Select without Tax ID as it's not password protected

- Direct link is also provided in any email received from Johnathan or myself

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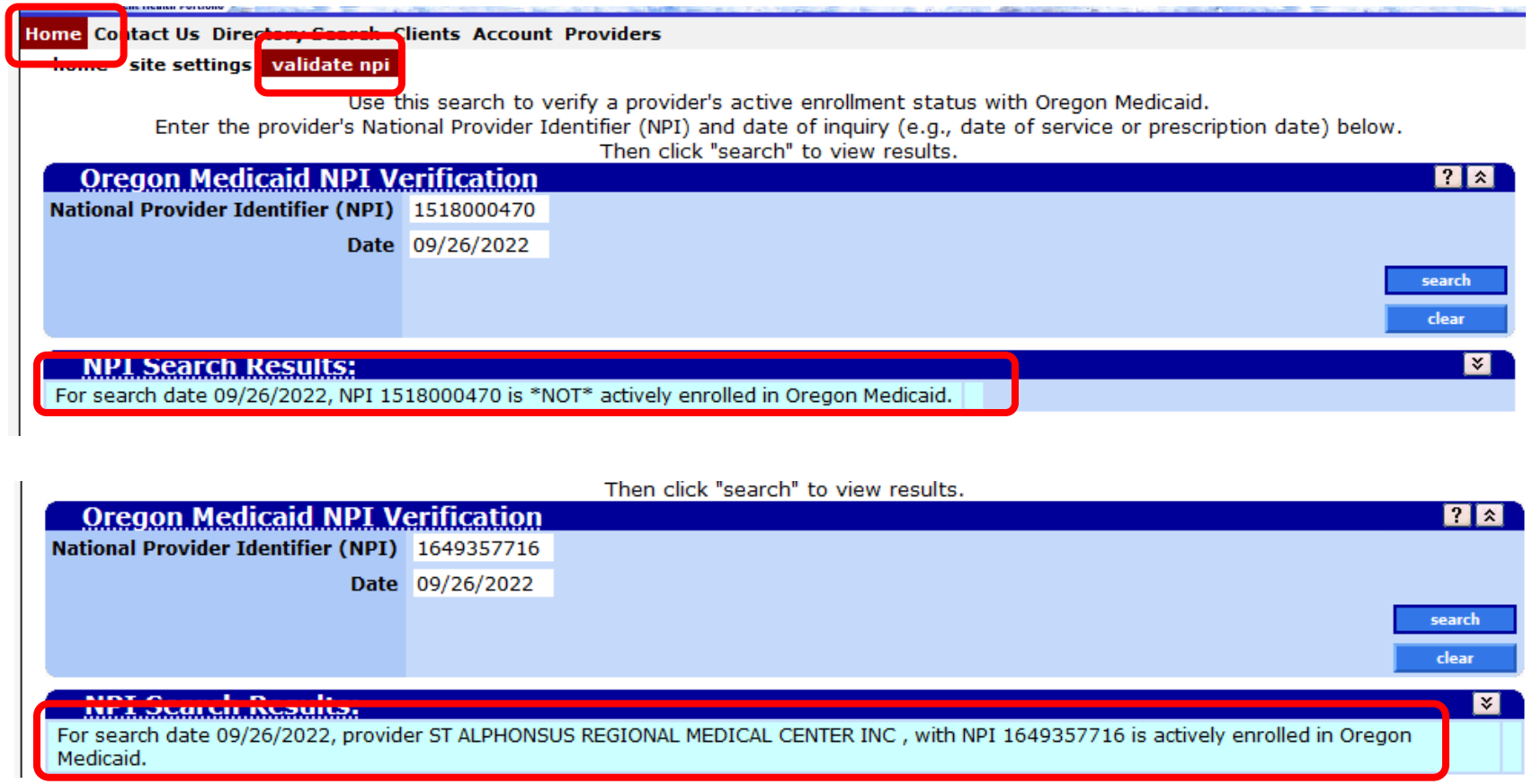
DMAP Enrollment



Value Based Payments

- Risk model withhold
  - 10% withhold of net amount due to provider is deducted services rendered by a participating Specialist or participating Hospital
  - Current model is 4/1/24-12/31/24 so that EOCCO can move to a 12 month model in 2025.
    - 2025 shared savings model will be from 1/1/25 to 12/31/25.

- Quality bonuses available to PCP's
  - Based on Quality Metrics performance

- Enhanced Risk Adjusted PCPCH PMPM
  - Clinic Tier Certification thru OHA www.oregon.gov/oha/HPA/dsi-pcpch/Pages/index.aspx
  - Risk Score 1-4
  - Higher per member per month (PMPM) rate for members with higher risk scores

- Capitation in lieu of FFS
  - Pays a PMPM based on member demographic
  - Providers must submit all claims

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Incentive Measures

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Incentive Measure Program Background

- OHA Committee selects measures and targets each year to show how well CCOs
  - Improve care
  - Make quality care accessible
  - Eliminate health disparities
  - Curb the cost of health care

- CCOs are awarded quality funds based on performance

- EOCCO uses their awarded funds for:
  - Primary care clinic quality bonus payments
  - Enhanced PCPCH payments
  - Dental Care Organization support
  - Community Mental Health Program (CMHP) incentive payments
  - Community Benefit Initiative Reinvestment (CBIR) grants

2024 Incentive Measures

Claims Based Measures

Data: Claims data + ALERT

- Child Immunization Status
- Assessments for Children in DHS custody
- Immunizations for Adolescents*
- Initiation and Engagement of Substance Use Disorder Treatment (IET)
- Oral Evaluation for Adults with Diabetes
- Preventive Dental Services Ages 1-5 & 6-14*
- Well-child Visits Ages 3-6 & 7-21*

Chart Review Measures

Data: EHR and Claims

- Timeliness of Prenatal and Postpartum Care*
- Meaningful Language Access to Culturally Responsive Healthcare Services (Language Access)
- Kindergarten Readiness: System-Level Social-Emotional Health*
- SDoH: Social Needs Screening & Referral

Clinical Quality Measures

Data: EHR

- Depression Screening and Follow-up
- Diabetes HbA1c Poor Control
- Cigarette Smoking Prevalence
- Alcohol and Drug Misuse Screening (SBIRT)

*2024 Challenge Pool Metric

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EOCCO Incentive Measure Program

- Clinics can track their performance on claims-based measures via monthly Quality Reports provided by EOCCO
    - Clinics also have the option to work with a Quality team member throughout the year on incentive measure initiatives

- Clinics may earn Quality Bonus Payments from the CCO at the end of the year depending on how many measure improvement targets they achieve
    - There is no penalty for *not* achieving measure targets

- Find more information on EOCCO's incentive measure program here: www.eocco.com/providers/incentivemeasures

- For questions specific to EOCCO quality and incentive measures, contact eoccometrics@modahealth.com

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Behavioral Health Services

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Great Oregon Behavioral Health Inc.

- Locations
  - The Dalles (Main Office)
  - Pendleton
  - La Grande

- Designated to oversee Behavioral Health on behalf of EOCCO in all 12 Counties

- Direct Services
  - Applied Behavioral Analysis (ABA)
  - Foster Care
  - Non-Emergent Medical Transportation Services
  - Wrap Around / Systems of Care
  - Oregon Center on Behavioral Health and Justice Integration
  - Early Assessment and Support Alliance (EASA)
  - Frontier Veggie Rx
  - Positive Parenting Program

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Utilization Management

- Hours of Operation & Contact Information
  - 541-298-2101
  - Monday-Friday
  - 8:00 a.m. to 5:00 p.m.

- Visit www.EOCCO.com for Authorization Information
  - List of Covered & Non-Covered & Authorization Requirements
  - Most Current Authorization Forms
  - Utilization Management Policies
  - Clinical Practice Guidelines
  - Information Needed for Specific Authorization Types

- Submit Authorization Request Via
  - Phone: 541-298-2101
  - Fax#: 541-296-1036
  - Email: UM@gobhi.org
  - Mail: 401 E 3rd St, Suite 101, The Dalles, OR 97058

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Additional Benefits & Resources

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Cribs for Kids®

- Free Safe Sleep Kit is available to pregnant mothers who receive prenatal or postpartum care that includes safe sleep education.

- Kit includes:
  - Graco Pack'n'Play
  - Halo SleepSack
  - Graco Pack'n'Play sheet with safe sleep message
  - ABC Magnet
  - Phillips Soothie Pacifier
  - Safe Sleep Educational Material & DVD
  - "Safe Baby Safe & Snug" Children's Book

- Forms located www.eocco.com/-/media/EOCCO/PDFs/crib_referral.pdf
  - Securely email them to eoccometrics@modahealth.com or fax to 503-265-4790 Attn: Medicaid Services

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Telemedicine

- Covered for all active EOCCO members
  - In or out-of-network providers are covered

- Covered services can be found on our telehealth guidance document www.eocco.com/providers/referral-auths

- Billing
  - Place of service (POS) 02 when member is in a place other than home
  - Use POS 10 when member is in their home
  - Use modifier 95 for physical health services, in addition to other appropriate modifiers
  - Use modifier GT for behavioral health services as outlined on the BH Fee-Schedule
  - Facilities can bill for telehealth/telemedicine services using Q3014 if treating patient in a health care setting

- EOCCO will pay for services that are allowed within your specific provider agreement

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Language Assistance

- EOCCO will provide interpreter services for eligible members

- Services are provided: Passport to Languages
  - Interpretation for of over 160 languages & dialects
  - Contact: 800-297-2707

- Information to provide:
  - Date & time interpreter is needed
  - Member name
  - Member ID number
  - Language needed
  - Callback number

- More information can be found on our flyer on EOCCO.com

Smoking Cessation/Prevalence

- Treatment Interventions basic (99406), intensive (99407) and telehealth

- Intensive treatment is covered if basic treatment is not successful
  - Documented quit date has been established
  - Will pay for a maximum of 10 sessions every three months for treatment & counseling

- Coverage includes
  - Nicotine gum, lozenges & patches
  - Prescriptions commonly used for quitting smoking & tobacco use

Transition of Care

- Continued access to services during a member's transition from a predecessor plan to EOCCO
  - A predecessor plan may be another CCO or Medicaid fee-for-service (FFS)
  - Primary care teams, hospitals & specialty service providers are required to meet requirements of transition of care

- We will provide coverage for the entire course of treatment for members who are receiving
  - Prenatal &/or postpartum care
  - First year of post-transplant year service
  - Current radiation or chemotherapy services; or
  - Prescriptions that exceed the transition of care period

- For a list of members that EOCCO will provide Transition of care to, please see our Provider Manual

Care Coordination

- Members can get care coordination from their patient-centered primary care home (PCPCH), primary care provider, or other primary care team

- Some examples include:
  - Explain & maximize available benefits & assist members & providers with timely access to needed services
  - Communicate with & assist providers with coordination of services & discharge planning & work with facility case managers to coordinate discharge plans
  - Contact members at home to confirm & support the provider's treatment plan, including coordination with providers to ensure that consideration is given to unique needs in treatment planning
  - Connect members with community resources & link members to social services
  - Assist members requiring special medical supplies or equipment, including children with special needs

- Referrals may be made using a referral form available on www.eocco.com/providers/referral-auths

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Local Community Health Partnership

- The Local Community Health Partnership (LCHP) is a group of locally identified volunteers from each of the 12 EOCCO counties who have interest in the health delivery system in their local community
- The goal of the LCHP is to engage members to take an active role in improving their own health & the health of their community
- Open to the public & comments are encouraged
- Local CAC Meeting Schedule & more information www.EOCCO.com/providers/cac

Community Health Workers

- Primary role is to serve as a link between a community and its health and social service systems in order to improve access to, and delivery of services, and build capacity for individuals/families/communities to promote their own health and well-being

- Does not cover social service such as enrollment assistance or case management

- Bill with one of the covered procedure codes outlined in our CHW policy:
  - Bill in 30-minute units: limit 4 units per 24 hours
  - No more than 8 units per calendar month per recipient
  - CHW is now the rendering provider

- More information can be found on www.EOCCO.com/Education
  - Next class September 23rd

Doulas

- A birth companion who provides personal, nonmedical support to birthing people and their families throughout the pregnancy, childbirth, and postpartum experience

- EOCCO will reimburse for Doula services

- Covers
    - Two pre-natal visits to the member
    - Support for the member at the day of the birth
    - Two post-partum visits to the member

- Billing
    - T1033 - HD for global benefit with support at delivery
    - T1033 - 22 for support at delivery Support for the member at the day of the birth
    - T1033 Support Visit (2 prenatal & 2 postpartum)

- Further information can be found in our Doula Policy

Health Related Social Needs (HRSN)

Climate

1. Medically necessary devices that maintain healthy temperatures and clean air including air conditioners, heaters, and air filters
2. Generators to operate medical devices like ventilators in a power outage

Housing

1. Rental assistance or temporary housing (up to 6 months)
2. Utility assistance (up to 6 months; tied to receiving #1)
3. One time transition and moving costs
4. Housing deposits and fees
5. Medically necessary home modifications
6. Pre-tenancy and tenancy support services
7. Navigation and/or case management for housing

Food

1. Nutrition and cooking education
2. Fruit and vegetable prescriptions (up to 6 months)
3. Meals (up to 3/day) or healthy food boxes for pregnant members, children, and YSHCN (up to 6 months)
4. Medically tailored meal delivery (up to 3/day; up to 6 months)
5. Navigation and/or case management for community-based food resources

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Climate-Related Support

- EOCCO Members who have a health condition that is worsened or may be negatively impacted by climate events such as extreme heat, extreme cold or poor air quality.

- Eligibility
  - Must be actively enrolled in EOCCO CCOA or CCOB plan
  - Must be part of one of the covered populations
  - Must meet at least one of the identified clinical risk factors for requested devices

- Devices
  - Air Conditioners
  - Air filtration devices
  - Mini refrigeration units
  - Portable power
  - Portland/Space Heaters

- Limitations
  - Once per member every 36 months for devices
  - Once per member every 12 months for air filter replacements

Clinical Risk Factors

- Younger than 6 years old & 65 years old or older
- Current pregnant
- Sensory, physical, intellectual, or developmental disability
- Take medication(s) that need to be refrigerated
- Use medical equipment that needs electricity to work
- Use assistive technology that needs electricity to work
- Have diabetes
- Have a chronic heart condition, such as heart failure, or Have had a heart attack
- Have a chronic condition that makes me at risk for blood clots or a stroke
- Have chronic lung conditions that require me to take medicine regularly to treat it such as chronic obstructive pulmonary disease (COPD), asthma, fibrosis, chronic bronchitis, bronchiectasis, or a restrictive lung disease
- Use oxygen at home
- Have a chronic kidney disease
- Have multiple sclerosis
- Have Parkinson's
- Have had a spinal cord injury
- Receive in-home hospice care
- Have had a heat-related illness in the past
- Have schizophrenia
- Have bipolar disorder
- Have major depressive disorder and have needed crisis services, hospitalization, or residential treatment in the past 12 months
- Have an alcohol or substance use disorder
- Have a major neurocognitive disorder that impacts my function, such as Alzheimer's dementia or a traumatic brain injury
- Get nutrition through tube feeding (enteral) or IV catheter (parental)
- Have another health condition that is not listed but may qualify

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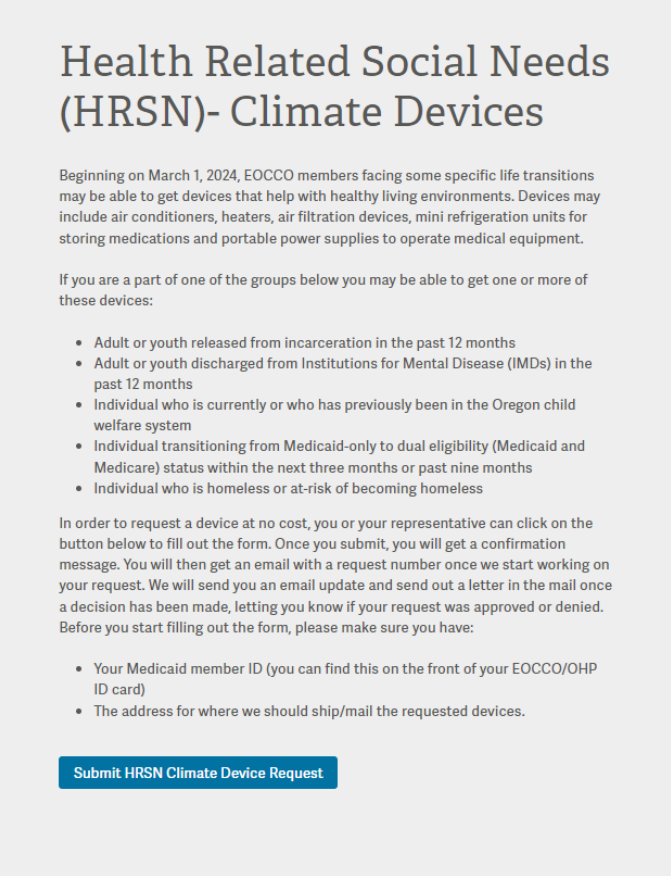
How to submit for an HRSN Benefit

Member Site



Health Related Social Needs (HRSN)- Climate Devices

Beginning on March 1, 2024, EOCCO members facing some specific life transitions may be able to get devices that help with healthy living environments. Devices may include air conditioners, heaters, air filtration devices, mini refrigeration units for storing medications and portable power supplies to operate medical equipment.

If you are a part of one of the groups below you may be able to get one or more of these devices:

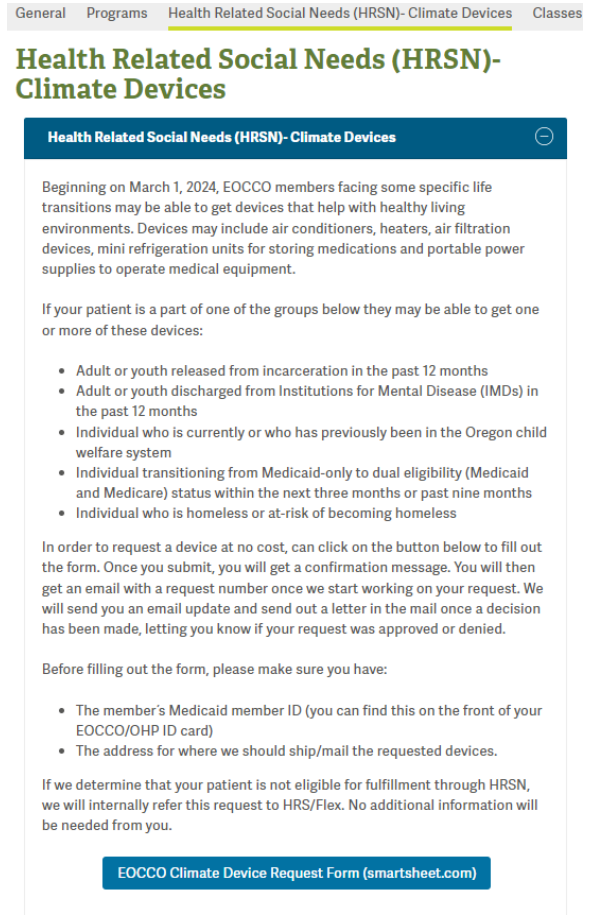
- Adult or youth released from incarceration in the past 12 months
- Adult or youth discharged from Institutions for Mental Disease (IMDs) in the past 12 months
- Individual who is currently or who has previously been in the Oregon child welfare system
- Individual transitioning from Medicaid-only to dual eligibility (Medicaid and Medicare) status within the next three months or past nine months
- Individual who is homeless or at-risk of becoming homeless

In order to request a device at no cost, you or your representative can click on the button below to fill out the form. Once you submit, you will get a confirmation message. You will then get an email with a request number once we start working on your request. We will send you an email update and send out a letter in the mail once a decision has been made, letting you know if your request was approved or denied. Before you start filling out the form, please make sure you have:

- Your Medicaid member ID (you can find this on the front of your EOCCO/OHP ID card)
- The address for where we should ship/mail the requested devices.

Submit HRSN Climate Device Request

Provider Site



General Programs Health Related Social Needs (HRSN)- Climate Devices Classes

Health Related Social Needs (HRSN)- Climate Devices

Health Related Social Needs (HRSN)- Climate Devices

Beginning on March 1, 2024, EOCCO members facing some specific life transitions may be able to get devices that help with healthy living environments. Devices may include air conditioners, heaters, air filtration devices, mini refrigeration units for storing medications and portable power supplies to operate medical equipment.

If your patient is a part of one of the groups below they may be able to get one or more of these devices:

- Adult or youth released from incarceration in the past 12 months
- Adult or youth discharged from Institutions for Mental Disease (IMDs) in the past 12 months
- Individual who is currently or who has previously been in the Oregon child welfare system
- Individual transitioning from Medicaid-only to dual eligibility (Medicaid and Medicare) status within the next three months or past nine months
- Individual who is homeless or at-risk of becoming homeless

In order to request a device at no cost, can click on the button below to fill out the form. Once you submit, you will get a confirmation message. You will then get an email with a request number once we start working on your request. We will send you an email update and send out a letter in the mail once a decision has been made, letting you know if your request was approved or denied.

Before filling out the form, please make sure you have:

- The member's Medicaid member ID (you can find this on the front of your EOCCO/OHP ID card)
- The address for where we should ship/mail the requested devices.

If we determine that your patient is not eligible for fulfillment through HRSN, we will internally refer this request to HRS/Flex. No additional information will be needed from you.

EOCCO Climate Device Request Form (smartsheet.com)

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Rent, Utilities Support Eligibility, Home Modifications & Remediation Eligibility

- Eligibility
  - Must be actively enrolled in EOCCO CCOA or CCOB plan
  - Must be part of one of the covered populations
  - Currently Housed (Non-homeowner)
    - Needs support staying housed for rent and utilities
    - Has a lease or written agreement with landlord
    - Scope of work document with landlord (if renting) for modifications
  - At Risk of Becoming Homeless
    - Has an income that is 30% or less than their area median income (based on HUD definition)
  - Has at least one Housing Clinical Risk Factor
    - Ex. Complex physical or behavioral health condition, developmental disability, recurrent ED utilization, over age 65, pregnant or 12 months postpartum and at risk of other clinical factors, under age 6 with risk of other clinical factors, repeated crisis encounters etc.

- Limitations
  - Rent Support/ Utilities: Once per month per household with one or more eligible members over the lifetime of the demonstration for up to 6 months
  - Home Modifications & Home Remediations: No limit

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Health Related Services (HRS)

- Flexible Services:
  - Cost-effective services delivered to an individual OHP member to supplement covered benefits and improve their health and well-being

- Community Benefit Initiatives:
  - Community-level interventions that include, but are not limited to, OHP members and are focused on improving population and health care quality

- Participating providers request authorization from EOCCO
  - Use the specific HRS form located www.eocco.com/providers/forms

- Medicaid covered services cannot be a Health-Related Service

Health Related Services (HRS) vs. HRSN

Health Related Services (HRS)/Flex Funds	Available since 2012 and paid for by the CCO to cover cost-effective items and/or services to supplement covered benefits. Meet immediate social needs, stabilize crisis situations and support a sustainable plan for ongoing needs. Funding mechanist to address social determinants of health (SDOH) Needs.	Oregon Administrative Rules restrict HRS to items not paid for with grant money, funding separate from CCO contract revenue, normal clinical service billing or in place for DME-covered items. HRSN Is always the payor of last resort and only available if there is no other funding options and criteria is met	Active EOCCO coverage, requested item/service serves an acute clinical need (evidence based) and a billing code does not exist (not a covered benefit).
Health-Related Social Needs	Available as of 3/1/2024 Paid under the State of Oregon 1115 Waiver Support 3 social and economic needs that impact an individual's ability to maintain health and well-being: climate, housing, food.	Limited to OAR and 1115 waiver coverage for eligible climate, housing and nutrition benefits/services.	Individuals must be eligible through HRSN screening process: 1. Meet priority/covered population requirement 2. Eligible clinical risk facts 3. Eligible social risk factors

Policies

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Nondiscrimination

- EOCCO and our providers comply with applicable state and federal civil rights laws. We cannot treat people (members or potential members) unfairly in any of our services or programs because of a person's

  - Age
  - color,
  - Disability
  - National origin
  - primary language and proficiency of English language
  - Race
  - Religion
  - sex
  - sex characteristics
  - gender identity
  - sex stereotype
  - pregnancy and related Conditions
  - health status or need for services.

- Everyone has the right to know about our programs and services. All members have a right to use our programs and services. We give free help when you need it. Some examples of free help we can give are: Sign language Interpreters, written material in other languages, spoken language interpreters for other languages, Braille, Large print, Audio and other formats

Timey Access to Care

Physical Health	
Regular appointments	Within 4 weeks
Urgent Care	Within 72 hours or as indicated in the initial screening
Emergency Care	Immediately or referred to an emergency department depending on your condition
Behavioral Health (BH)	
Routine behavioral healthcare for non-priority populations	Assessment within 7 days of the request, with a second appointment scheduled as clinically appropriate
Urgent behavioral healthcare for all populations	Within 24 hours
Crisis Behavioral Health Services	24 hours - 7 days a week
IV drug users including heroin	Immediate assessment and entry. Admission for services in a residential level of care is required within 14 days of request, or, placed within 120 days when put on a waitlist because there are no providers available
Opioid use disorder	Assessment and entry within 72 hours
Medication assisted treatment	As soon as possible, but no more than 72 hours for assessment and entry
Oral Care	
Dental Emergency services	Seen or treated within 24 hours
Oral and dental care for children and non-pregnant people	
Regular oral health appointments	Within 8 weeks unless there is a clinical reason to wait longer
Urgent oral care	Within 2 weeks
Oral and dental care for pregnant people	
Routine oral care	Within 4 weeks unless there is a clinical reason to wait longer
Urgent dental care	Within 1 week

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Rights & Responsibilities

- Member rights & responsibilities are provided to members upon enrollment in EOCCO via the Member Handbook
    - Can also be found in OAR 410-141-3590

- Examples
    - Be treated with dignity & respect
    - Be actively involved in the development of their treatment plan
    - Allowed to make decisions about their healthcare
    - Receive a referral to specialty providers for medically appropriate covered coordinated care services
    - Have a consistent & stable relationship with a care team that is responsible for comprehensive care management
    - Have access to one's own clinical record as well as transfer of those records, unless restricted by statute

Member Dismissals

- A member can be dismissed for:
  - Missed appointments, except prenatal care patients
  - Disruptive, unruly or abusive behavior
  - Drug-seeking behavior
  - Committing or threatening an act of physical violence
  - Committing a fraudulent or illegal acts

- A member can't be dismissed for:
  - Has a physical, intellectual, developmental, or mental disability
  - The member requests a hearing
  - The member has been diagnosed (ESRD)
  - The member exercises his or her option to make decisions regarding his or her medical care with which the provider or the plan disagrees
  - The member displays uncooperative or disruptive behavior, including but not limited to threats or acts of physical violence, resulting from the OHP member's special needs

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Member Responsibility Waiver

- Required in-order to bill member for services not covered by the Oregon Health Plan &/or EOCCO per OAR 410-120-1280
- Must review & have member's signature prior to service being performed
  - Service must be performed within 30 days of signature & discussed fees cannot change
- Providers must make a copy of the completed form & keep on file to make available upon request
- Forms are located www.eocco.com/providers/forms

Member Grievances

- A complaint is an expression of dissatisfaction to EOCCO or a provider about any matter that does not involve a denial, limitation, reduction or termination of a requested covered service
    - Examples include, but not limited to, access to providers, waiting times, demeanor of medical care personnel, quality of care & adequacy of facilities

- Providers are encouraged to resolve complaints, problems & concerns brought to them by their EOCCO patients but if you cannot resolve a complaint yourself, please inform the member that we have a formal complaint procedure

- The grievance coordinator will send a resolution letter within 30 days of when the complaint was received.

Member Appeals

- A member appeal can be submitted to EOCCO by a member or a provider, on the member's behalf
    - Members can request in writing and verbally through the customer service department Must be requested within **60 days** of the determination
    - Must have members permission if provider will submit on members behalf

- If the appeal decision is upheld, the member is informed of their right to request an administrative hearing through the Office of Administrative Hearings (OAH). The appeal staff sends a written Notice of Appeal Resolution (NOAR) within 16 days of receipt for an appeal
    - A 14-day extension may be utilized if additional information is needed (total 30 days)

Provider Appeals

- Initial applicant provider & participating providers have 60 calendar days following the receipt of the medical director's letter of the Moda Health decision to take adverse action against the provider's or practitioners participating status

- Retro authorization request after the claim has processed need to be submitted as an appeal within 90 days of the date of service

- A written request would be mailed to the medical director by certified mail

- If a provider has a question regarding claims status, member eligibility, payment methodology, medical policy or third-party issues, please send a written request to:

  EOCCO Provider Appeals
  PO Box 40384
  Portland, OR 97240

Notice of Adverse Benefit Determination (NOABD) letters

- Required to be sent out to members and providers
  - If we deny, stop, or reduce a medical, dental or behavioral health service
  - When a pre-service determination is denied
  - Claim denials

- Began sending out March of 2023 manually
  - Automated as of July 2023

Restraints & Seclusion

- In accordance with federal law, we recognize that each patient has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation

- Restraints or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, staff members or others from harm
    - The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member or others from harm

- In addition, the nature of the restraint or seclusion must take into consideration the age, medical & emotional state of the patient
    - Under no circumstances may an individual be secluded for more than one hour

Fraud, Waste and Abuse

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Introduction-Why FWA Training?

- Every year billions of dollars are improperly spent because of Fraud, Waste and Abuse (FWA). Our provider partners play an important role in detecting, correcting and preventing FWA. You are part of the solution!

- This training will cover:
  - Defining Fraud, Waste and Abuse and proving examples of each
  - Relevant Federal and State laws related to FWA
  - Potential consequences and penalties associated with violations
  - How to report Fraud, Waste and Abuse
  - Proper billing practices

- After this training you will be asked to attest that you have reviewed and understand this training. If you have any questions, please reach out to EOCCO's Compliance Officer, Nick Gross, at EOCCOCompliance@eocco.com

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What is Fraud?

- Fraud is *knowingly* submitting, or causing to be submitted, false claims or making misrepresentation of fact to get health care payment when no entitlement would otherwise exist. Fraud requires *intent* to get payment and *knowledge* the actions are wrong.

- Examples of Fraud include:
    - Knowingly billing for services of higher complexity than services actually provided or documented in the patient medical records
    - Knowingly billing for services or supplies not provided, including falsifying records to some item delivery
    - Knowingly ordering medical unnecessary patient items or services

What is Waste?

- Waste describes practices that, directly or indirectly, result in unnecessary health plan costs, like over-using services. Waste is generally not considered to be criminally negligent but rather a misuse of resources.

- Examples of Waste include:
    - Conducting excessive office visits or writing excessive prescriptions
    - Prescribing more medications than necessary to treat a specific condition
    - Ordering excessive lab tests

What is Abuse?

- Abuse describes practices that, directly or indirectly, result in unnecessary health plan costs.

- Examples of Abuse include:
    - Any practice that does not provide patients with medically necessary services or meet professionally recognized standards
    - Unknowingly billing for unnecessary medical services
    - Unknowingly billing for brand name drugs with generics are dispensed
    - Unknowingly charging excessively for services or supplies
    - Unknowingly misusing codes on a claim, such as upcoding or unbundling

What are the Differences

- There are differences between fraud, waste and abuse. One of the primary differences is *intent* and *knowledge.*

    - Fraud requires *intent* to obtain payment and *knowledge* that actions are wrong

    - Waste and abuse may involve getting an improper payment or creating unnecessary health plan costs but do not require the same intent and knowledge

Understanding FWA Laws- False Claims Act

- In order to detect FWA you need to know the law. These slides outline pertinent FWA laws you should be familiar with.

- The **Civil False Claims Act (FCA)** (31 USC 3729-3799) makes a person liable to pay damages to the government if they knowingly:
    - Conspire to violate the FCA
    - Carry out other acts to get government property by misinterpretation
    - Conceal or improperly avoid or decrease an obligation to pay the Government
    - Make a false record or statement supporting a false claim
    - Present a false claim for payment or approval

- Penalties for violating the civil FCA may include recovery of up to 3 times the amount of the government's damages due to the false claims, plus $11,000 per false claim.

Understanding FWA Laws-Whistleblower Protections

- Exposing a false claim scheme can be rewarding!
- A whistleblower is a person who exposes information or activity that is deemed illegal, dishonest or violates professional or clinical standards.
- Those who report false claims or bring legal action to recover money paid on false claims are protected from retaliation.
- A person who brings a successful whistleblower lawsuit gets at least 15%, but not more than 30%, of the money the government collects.

Understanding FWA Laws-Criminal Health Care Fraud Statute

- The **Criminal Health Care Fraud Statute** (18 USC 1346-1349) states: "Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program, or obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program….shall be fined under this title or imprisoned not more than 10 years, or both".

- Conviction under the statute does not require proof the violator had knowledge of the law or specific intent to violate it.

Understanding FWA Laws-Anti-Kickback Statue

- The **Anti Kickback Statue** prohibits knowingly and willfully soliciting, receiving, offering, or paying remunerations (including any kickback, bribe, or rebate) for referrals for services that are paid, in whole of in part, under a Federal health care program.

- Example: A physician operating Rhode Island pain management clinic
  - Solicited kickbacks for prescribing a highly addictive version of the opioid Fentanyl
  - Reported patients had breakthrough cancer pain to secure insurance payments
  - Got $188,000 in speaker fee kick backs from the drug manufacturer
  - Admitted to the kickback scheme cost Medicare and other payers more than $750,000
  - The physician was required to pay back more than $750,000 in restitution

Understanding FWA Laws- Physician Self-Referral Law

- The **Physician Self-Referral Law** (42 USC 1395nn), often called the Stark Law, prohibits a physician from referring a patient to get designated health services from a provider with whom a physician or physician's immediate family member has a financial relationship, unless an exception applies.

- A penalty of approximately $25,000 can be imposed for each service provided. There may also be a fine over $160,000 for entering into am unlawful arrangement or scheme.

Understanding FWA Laws-Civil Monetary Penalties Law

- The **Civil Monetary Penalties Law** (42 USC 1320a-7a), the Office of Inspector General (OIG) may impose penalties for several reasons, including:
  - Arranging for services or items from an excluded individual or entity
  - Violating the Anti-Kickback Statute
  - Making false statements of misrepresentations on applications or contracts to participate in federal health care programs
  - Failing to grant OIG access to records
  - Knowing of and failing to report and return overpayments
  - Submitting fraudulent claims

- Damages and penalties can be $15,000 to $70,000 depending on the violation. Violators are also subject to three times the amount claimed for each service or item of remuneration offered, paid, solicited or received.

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Understanding FWA Laws-Exclusion Statute

- The **Exclusion Statute** (42 USC 1320a-7), requires the OIG to exclude individuals and entities convicted of these offenses from participating in all federal health care programs:
  - Medicare or Medicaid Fraud, as well as offenses related to delivering Medicare or Medicaid items or services
  - Patient Abuse or Neglect
  - Felony Convictions for other health care related fraud, theft, or other financial misconduct
  - Felony Convictions for unlawful manufacture, distribution, prescribing, or dispensing controlled substances

- For Medicaid, any excluded providers identified during the credentialing process must be immediately reported to HHS-OIG.

Understanding FWA Laws- Oregon Medicaid Anti-Fraud Statute and Oregon False Claims Act

- The **Oregon Medicaid Anti-Fraud Statute** (ORS), prohibits any person from submitting a fraudulent claim for payment with respect to the Medicaid program. Additionally, in Oregon it is a crime to knowingly make a false claim with respect to payment for health care items or services to knowingly conceal or fail to disclose a material fact with intent to obtain such payment. A person found to have violated this prohibition is liable to the State for three times the amount of damage incurred by the State.

- The **Oregon False Claims Act** (ORS 180.755) is similar to the federal False Claims Act and prohibits any person or entity from submitting a false claim to any public agency, including Oregon's Medicaid program. Penalties for violating the Oregon False Clams Act are the greater of $10,000 for each violation or an amount equal to twice the amount of damages incurred for each violation.

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Your Responsibilities- Reporting FWA

- It is your responsibility to report Fraud, Waste and Abuse directly to EOCCO and/or to the Medicaid Fraud Control Unit or OHA Office of Program Integrity.

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
3406 Cherry Ave. NE
Salem, OR 97303-4924
Fax: 503-378-2577
Hotline: 1-888-FRAUD01 (888-372-8301)

- Allegations can also be reported anonymously through EthicsPoint using this link: NAVEX - Incident Reporting (ethicspoint.com)

- Or you may contact EOCCO's Compliance Officer, Nick Gross, at EOCCOCompliance@EOCCO.com

Your Responsibilities- Proper Billing Practices

- To ensure timely and accurate claims payment, please remember the following:
  - Timely filing is 120 days from the date of service
  - Verify member eligibility and prioritized line coverage at the time of service
  - Include all valid, appropriate ICD-10 codes, CPT codes and modifiers
  - Have an active DMAP number and use the correct NPI and TIN number
  - Use standard CMS 1500 or CMS1450 claim forms
  - Payment is made via EFT/ERA or Zelis
  - Medicaid is payer of last resort (except for VFC)
  - Participating providers agree to bill EOCCO for covered OHP services, members should not be asked for payment
  - Providers are required to report and return any overpayment promptly, but no later than 60 days after identification

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Conclusion

- Thank you for taking the time to review this training and to be good stewards of public funds. You play a vital role in preventing, detecting and reporting potential FWA and EOCCO appreciates your continued partnership!

- If you have questions about the content of this training, please contact

Nick Gross
EOCCO Compliance Officer
EOCCOCompliance@eocco.com
503-952-5033

- This training along with EOCCO's Fraud, Waste and Abuse policies can be found here for reference: EOCCO provider - education

Looking Ahead

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Nutrition-Related Support Limitations

- Eligibility
  - Must be actively enrolled in EOCCO CCOA or CCOB plan
  - Attest to experiencing low food security

- As of January 2025
  - Medical Tailored Meals
  - Assessment for Medically Tailored Meals
  - Nutrition Education

- Coming later in 2025
  - Pantry Stocking
  - Meals
  - Fruit & Vegetable Benefit

- Limitation
  - Up to 6 months at which time member may be reassessed for service eligibility
  - No limit to duration of benefit with proper authorizations.

- Limitation
  - Up to 6 months. Once per household with one or more eligible member(s) over the lifetime of the demonstration (through August 2027).

This benefit can be used in tandem with other nutritional supports such as WIC, SNAP, TANF

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Youth with Special Healthcare Needs (YSHCN)

- Extending certain benefits to young adults, between 19 and 26, who have special health care needs and meet other eligibility criteria
- EPSDT rules will apply to these members
- Begin with ages 19 through 20 for 2025
    - In future years, additional age groups will be phased in by increasing the upper age limit of enrollees
- Identified via a PERC
- Individual or family income up to 205% percent of the Federal Poverty Level

Contacting EOCCO

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Contacting EOCCO

- EOCCO Medical Customer Service
  - 503-765-3521
  - 888-788-9821 (toll-free)
  - EOCCOmedical@eocco.com
- For provider concerns, issues or questions
  - EOCCOproviderinquiry@modahealth.com
- Incentive Measure questions
  - EOCCOmetrics@modahealth.com
- Lead Medicaid Professional Relations Rep
  - Noah.Pietz@modahealth.com
  - 503-265-4786

Contacting EOCCO: Reports & Newsletter

- Sent out on monthly basis for
- Progress Reports
  - EOCCOmetrics@modahealth.com
- Risk Reports (Member Roster, ER & IP Detail, Pharmacy Opportunity Report)
  - ProviderReports@modahealth.com
- PCPCH/ PCP Capitation reports
  - EOCCOproviderinquiry@modahealth.com
- EOCCO Monthly Newsletter
  - eoccoproviderinquiry@modahealth.com

Important Contacts

- ODS Community Dental: 1-800-342-0526
  - www.odscommunitydental.com
- Advantage Dental: 1-866-268-9631
  - www.advantagedental.com
- EOCCO Pharmacy Customer Service: 888-474-8539
  - Pharmacy benefits
- Behavioral Health: 800-493-0040
  - Behavioral health & SUD benefits
- Non-emergency medical transportation: 877-875-4657
- eviCore: 844-303-8451
  - Advanced imaging, radiology, cardiology authorizations
  - www.eviCore.com
- Prime Therapeutics Management Specialty Pharmacy: 800-424-8114
  - Specialty drug authorizations
  - www1.magellanrx.com/medical-rx-prior-authorization/

EOCCO Resources

- 2024-EOCCO-Incentive-Measure-Guide.pdf
- EOCCO provider – education
- Provider Reports Portal
- EOCCO Printed Resource Request Form
  - To order additional EOCCO resources for members and providers please scan the QR code or visit https://tinyurl.com/EOCCO-Resource-Request

Questions?

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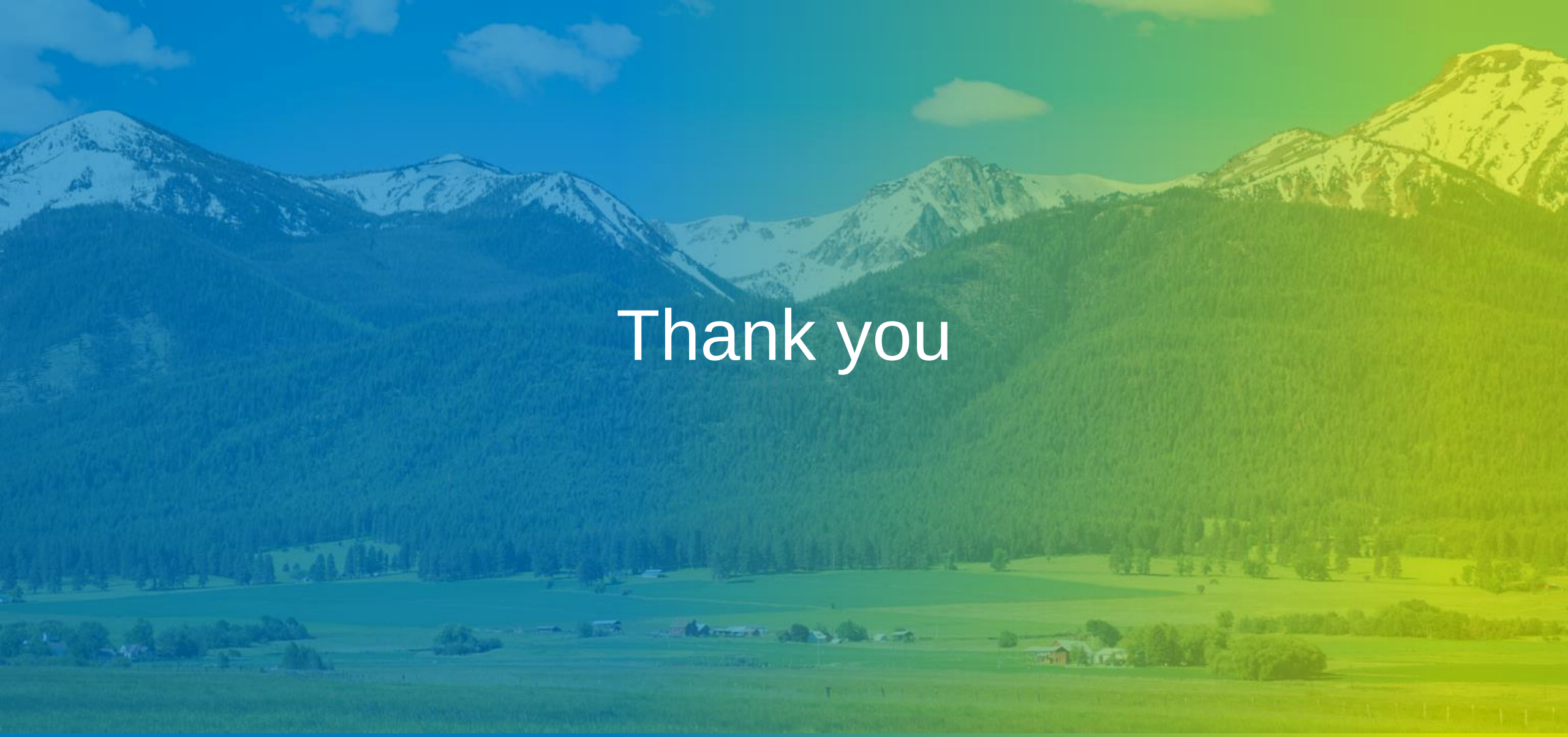
As of 1/1/25 Summit Health will be no longer be active for members

SUMMIT HEALTH



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