Providence

2025 Annual Compliance, Medicare and Medicaid Fraud and Abuse, Privacy and Security Awareness *with MSSP ACO* Training for Providers

CME Accreditation

Faculty Disclosure Summary

The content of this activity is not related to products or services of an ACCME-defined ineligible company; therefore no one in control of content has a relevant financial relationship to disclose and there is no potential for conflicts of interest. All planners and presenters attested that their content suggestions and/or presentation(s) will provide a balanced view of therapeutic options and will be entirely free of promotional bias. All presentations have been reviewed by a planner with no conflicts of interest to ensure that the content is evidence-based and unbiased.

The information provided addresses several requirements of the Accreditation Council for Continuing Medical Education (ACCME) to help ensure independence in CME activities. Everyone in a position to control the content of a CME activity must disclose all relevant financial relationships with ineligible companies to the CME provider. This information must be disclosed to participants prior to the beginning of the activity. Also, CME providers must mitigate relevant conflicts of interest prior to the educational activity. The ACCME defines "ineligible companies" as those whose primary business is producing, marketing, selling, re-selling or distributing healthcare products used by or on patients. Among the exemptions to this definition are government organizations, non-health care related companies and non-profit organizations that do not advocate for commercial interests. Circumstances create a "conflict of interest" when an individual has an opportunity to affect CME content about products or services of an ineligible company with which he/she has a financial relationship. ACCME focuses on financial relationships with ineligible companies in the 24-month period preceding the time that the individual is being asked to assume a role controlling content of the CME activity. ACCME has not set a minimal dollar amount for relationships to be significant. Inherent in any amount is the incentive to maintain or increase the value of the relationship. The ACCME defines "relevant financial relationships" as financial relationships in any amount occurring within the past 24 months that create a conflict of interest.

Accreditation with Commendation

CME Accreditation Information

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Swedish Medical Center and Providence St. Joseph Health. Swedish Medical Center is accredited by the ACCME to provide continuing medical education for physicians.

AMA PRA Category 1 Credits™

Swedish Medical Center designates this internet enduring material for a maximum of 1.0 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Providence SWEDISH

Compliance At Providence

- The Compliance program's main function is to recognize and prevent regulatory risk.
- The Compliance applies to all workforce members, including our independent physicians.
- Compliance Services manages Providence's Code of Conduct, compliance and privacy policies, Conflicts of Interest disclosure program, Exclusion Screening program, and educates on the various healthcare laws.
- Compliance Services has a presence in each division (North, South, and Central) and at each ministry we serve. CLICK HERE for a contact list.

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Chief Compliance Officer (CCO)

- Providence has designated a CCO who is responsible for oversight of the Compliance Program

Chief Compliance Officer,
David Lane, Ph.D.

- The CCO strives to implement the seven elements of an effective compliance program as out lined in the General Compliance Program Guidance (GCPG)published by the OIG.
    - 1. Written Policies and Procedures, including a Code of Conduct
      2. Compliance Leadership and Oversight
      3. Training and Education
      4. Effective Lines of Communication and Disclosure Programs
      5. Enforcing Standards: Consequences and Incentives
      6. Risk Assessment, Auditing, and Monitoring
      7. Responding to Detected Offenses and Developing Corrective Action Initiatives

- The CCO is available to workforce members to answer compliance questions.

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Code of Conduct (COC)

- The Compliance Program owns and is responsible for the upkeep of our organization's Code of Conduct and the Code of Conduct policy. All workforce members are asked to review and agree to abide by the COC on a yearly basis while working for Providence.

- The COC was designed in a way to make it accessible for all workforce members. The COC provides overviews on important topics such as:
  - Culture of diversity and respect
  - Quality of care and patient safety
  - Ethical and legal standards
  - Safeguarding patient information and protecting privacy and confidentiality
  - Compliance with applicable federal and state laws and regulations and policies
  - Duty to report suspected violations and protection from retaliation

- The COC reinforces our organizations values, which drive our actions and the principles that underlines decision making. Therefore, the Code becomes the most important part of the organization's ethical framework.

- The code is available in 7 different languages.

You can access our COC anytime on our Providence.org site:
https://www.providence.org/about/integrity-and-compliance/code-of-conduct#tabcontent-1-pane-2

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September 2023

Doing the Right Thing Right

Our Code of Conduct




Ways to report a compliance, privacy, or other concern

- Discuss the matter or concern with your immediate supervisor
- Discuss the matter or concern with your department leader
- Discuss with your HR Partner, HR Service Center, or send report via HR Portal
- Contact your local or regional compliance or privacy representative
- Call the 24/7 Integrity Hotline at 888-294-8455 or use Integrity Online, our Web-based reporting option
- For Caregivers in India:
  - From an outside line, dial the direct access number: 000-117
  - At the English prompt dial 888-294-8455

You may report concerns anonymously

To report a quality or patient safety concern

- Discuss the matter or concern with your immediate supervisor
- Discuss the matter or concern with your department leader
- Discuss with your Quality leader or representative
- Call the 24/7 Integrity Hotline at 888-294-8455 or use Integrity Online, our Web-based reporting option
- HRP- High Reliability Platform
  - Must be on organization network to report

SPEAK UP FOR SAFETY

Culture of Diversity and Respect

We adhere to all laws and regulations and are committed to a workplace culture where all individuals are treated with respect and dignity, regardless of protected characteristics, as defined by local, state, or federal law, including but not limited to race, color, religious creed (including religious dress and grooming practices), national origin (including certain language use restrictions), ancestry, disability (mental and physical including HIV and AIDS), medical condition (including cancer and genetic characteristics), genetic information, marital status, age, sex (which includes pregnancy, childbirth, breastfeeding and related medical conditions), gender, gender identity, gender expression, sexual orientation, and military and veteran status. POLICY

Quality of Care and Patient Safety

We commit to provide the best, *compassionate* care and service every time and strive to meet and exceed national standards for quality and patient *safety*. Workforce members have the responsibility and obligation to report any Quality of Care and Patient Safety issues. POLICY

Stewardship of Resources

We commit to effective stewardship of resources in support of patient care and organizational goals and only use resources for legitimate business purposes. POLICY

Conflicts of Interest (COI) Commitment

We will avoid actual or perceived COI and agree to disclose any outside interests or activities, contracts, and relationships that may be in conflict to the organization. We maintain impartial relationships with vendors, research sponsors, and contracts by not requesting or accepting gifts, cash, or cash equivalents. POLICY

Ethical and Legal Standards

We conduct ourselves in a professional and ethical manner in support of *justice* and will perform our job duties in accordance with all federal, state, and local laws. POLICY

Safeguarding Patient Information and Protecting Privacy and Confidentiality

We take every precaution to safeguard patient information, and we will treat protected health information (PHI) of all with special care and follow all federal, state, and local laws. POLICY

Ethical Conduct of Research

We follow the highest ethical standards and comply with all laws, regulations, guidelines, and ethical directives (where applicable) that govern human, animal, and basic applied science research. POLICY

Licensure and Certification

We require all health care and education professionals to follow all federal, state, and local laws applicable to licensing, credentialing, and certification requirements. Individuals on the excluded provider lists cannot work for our organization. POLICY

Compliance with Applicable Federal and State Laws and Regulations, and Policies

We ensure *excellence* by requiring all parties that work for or on behalf of an employer within our family of organizations learn and follow all laws, regulations, and policies. POLICY

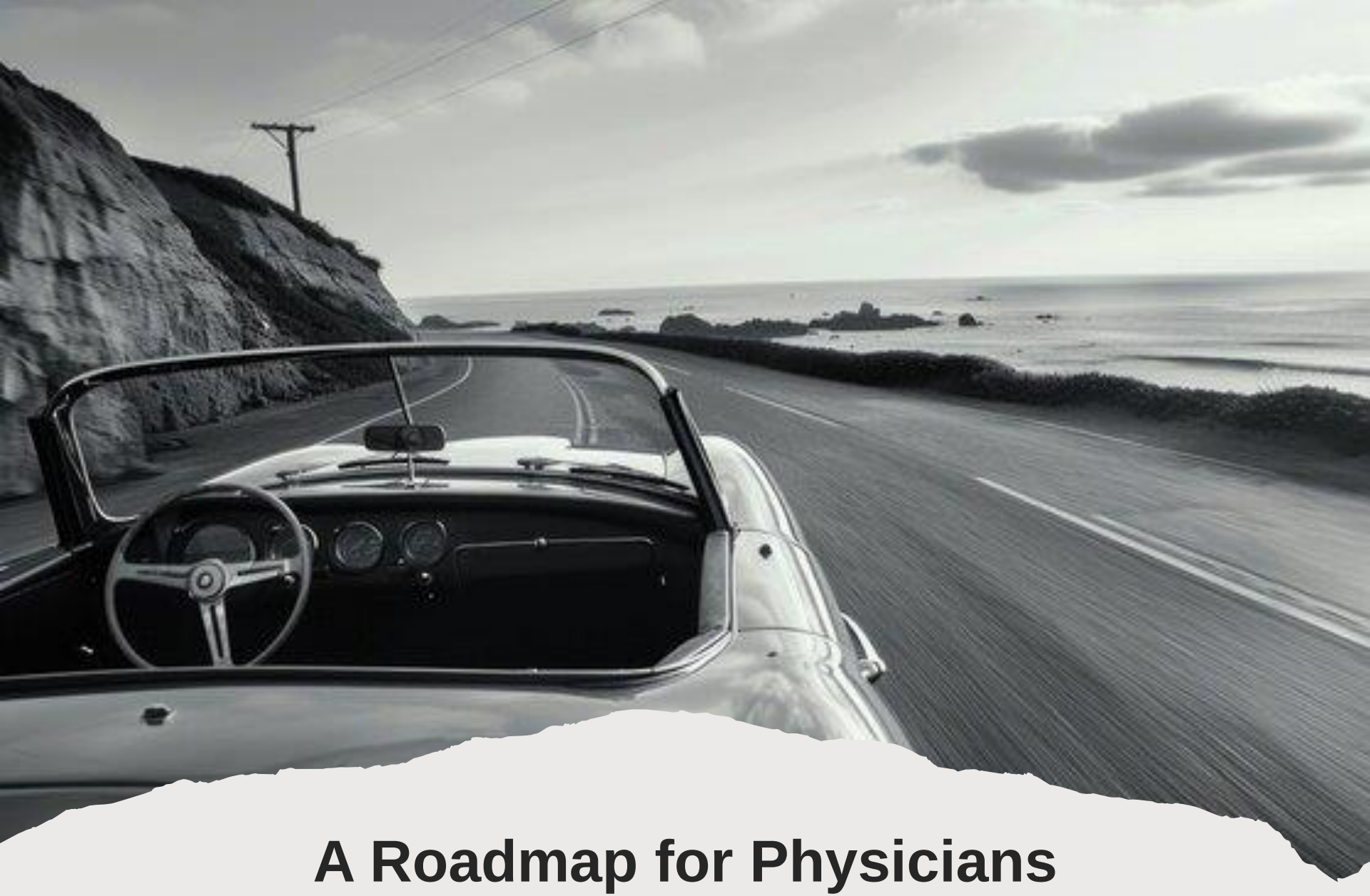
Fair Business Practices

We conduct ourselves ethically, honestly, and with *integrity* at all times. POLICY

Duty to Report Violations and Protection from Retaliation

It is every workforce member's responsibility to report, in good faith, any violation or suspected violations of our code, fraud, waste, abuse or quality or patient safety concerns as required. Providence's Non-Retaliation policy, and to an extent, government law, protects workforce members from retaliation or harassment for having raised concerns about actual or potential wrongdoing or misconduct ". POLICY

Our mission, vision, values, and promise provide guidance and inspiration as we deliver quality care, make sound, ethical choices, and meet our organizational goals. As workforce members, we are accountable for the integrity of our decisions and actions on the job. We are obligated to report any suspected violations or concerns. The Code of Conduct provides a foundation of expectations for us as we do our work each day.



A Roadmap for Physicians

Avoiding Medicare and Medicaid Fraud and Abuse

CLICK HERE to download your own copy of this Roadmap

Health Care Fraud is a Serious Problem

- The Government spends almost a trillion dollars each year on the Medicare and Medicaid programs.
- Although there is no precise measure of health care fraud, experts estimate that fraudulent billings to the programs are in the range of 3–10 percent.
- **That means that fraud, waste, and abuse cost taxpayers $30 billion to $100 billion dollars each year.**
- Not only does fraud drain the taxpayers' money, it also puts beneficiaries' health and welfare at risk by exposing them to unnecessary services and taking money away from needed patient care.
- When the Federal Government recovers money from fraud cases, it returns the money to the Medicare Trust Fund to pay for legitimate patient care.

Fraud, Waste, and Abuse

Fraud includes obtaining a benefit through intentional misrepresentation or concealment of material facts.

Waste includes incurring unnecessary costs as a result of deficient management, practices, or controls.

Abuse includes any practice that is not consistent with the goals of providing patients with services that (1) are medically necessary, (2) meet professionally recognized standards, and (3) are priced fairly.

Fraud and Abuse Laws

Physicians are an important part of protecting the integrity of the Medicare and Medicaid programs. The Government needs physicians to understand the fraud an abuse laws so that you can be partners in preventing fraud, waste, and abuse.

1. The False Claims Act;
2. The Anti-Kickback Statute;
3. The Physician Self-Referral Statute
4. Exclusion Provisions; and
5. The Civil Monetary Penalties Law

For more information, click HERE for a Fact Sheet.

1. False Claims Act

Prohibits the submission of false or fraudulent claims to the Government

Claims may be false if the service is not actually rendered to the patient, is provided but already covered under another claim, is miscoded, or is not supported by the medical record.

For False Claims Act violations, you can be fined up to three times the program's loss, plus **$13,946 per claim**.

For example: a hospital compensated its physicians in a way that violated the Stark Law against physician self-referrals therefore violating the False Claims Act. The hospital had submitted 21,730 false claims to Medicare with a total value of $39,313,065. The district court assessed 21,730 civil False Claims Act penalties. Ultimately, the hospital was on the hook for **$119,515,000** in False Claims.

Deliberate Ignorance

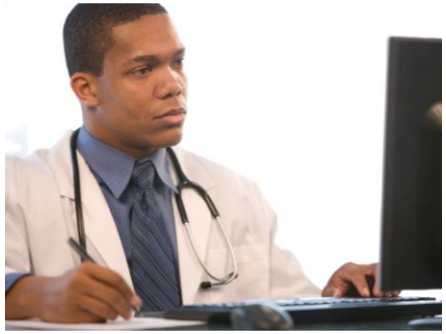
You do not have to intend to defraud the Government to violate the False Claims Act. You can be punished if you act with **deliberate ignorance or reckless disregard** of the truth.

Accurate Coding and Billing

Forms of medical billing fraud include duplicate billing, phantom billing, upcoding, under coding, medical equipment fraud, and billing separately for services already included in a global fee.

Accurate medical records are critical

The Medicare and Medicaid programs may review the patient's medical records to verify the claim, as well as the quality of care. If the medical record does not support the claimed service, the claim may be denied.



Good documentation helps ensure quality patient care

Good documentation is also a quality of care issue. It helps ensure that your patients get the best possible clinical care from you and other providers who may rely on your records.

If you have questions about coding and documentation, ask someone you trust.

Participating Physicians…

- Most physicians bill Medicare as participating physicians and receive Medicare's 80 percent directly from Medicare and bill patients for the remaining 20 percent.

- This means that you accept the Medicare payment, plus any copayment or deductible Medicare requires the patient to pay, as the full payment. You may not require any extra payment from your patient.

- In other words, you may not ask Medicare patients to pay a second time for services for which Medicare has already paid.

Non-Participating Physicians…

- Bill directly to patients
- Patients reimbursed by Medicare
- It is illegal to charge more than 15% above the Medicare rate

Incentives to Report Fraud

The False Claims Act also provides a strong financial incentive to whistleblowers to report fraud. Whistleblowers can *receive up to 30 percent* of any False Claims Act recovery.

Often whistleblowers turn out to be ex-business partners, hospital or office staff, competitors, or even patients. Data analytic companies are increasingly becoming whistleblowers. Check out this press release from December 12, 2024

PRESS RELEASE

California Hospital to Pay $10.25M to Resolve False Claims Allegations

Thursday, December 12, 2024

For Immediate Release

Office of Public Affairs

2. Anti-Kickback Statute (AKS)

The AKS is a federal criminal law and applies to both payers and recipients of kickbacks. The law prohibits obvious kickbacks, like cash for referrals, as well as more subtle kickbacks, like free rent, below fair market value rent, free clerical staff, or excessive compensation for medical directorships.

As a result, violation of the AKS is **a felony punishable by a maximum fine of $100,000, imprisonment up to 10 years, or both**. Conviction also will lead to mandatory exclusion from Federal health care programs, including Medicare and Medicaid.

Violation of the **AKS also triggers liability under the Civil Monetary Penalties Law (CMPL)**. The CMPL carries penalties of **up to $50,000 per kickback**, in addition to three times the amount of the remuneration. It also makes the resulting bills to the government false under the False Claims Act. As a result, the violator is responsible for three times the value of the bills, and a False Claims Act Penalty of **up to $27,894 per bill**.

Numerous physicians have been sanctioned under the False Claims Act by the Justice Department or by private individuals in a qui tam proceeding for selling their product loyalty to drug or device companies or other vendors.

3. Physician Self-Referral Law [42 U.S.C. § 1395nn]

Commonly referred to as the *Stark Law*

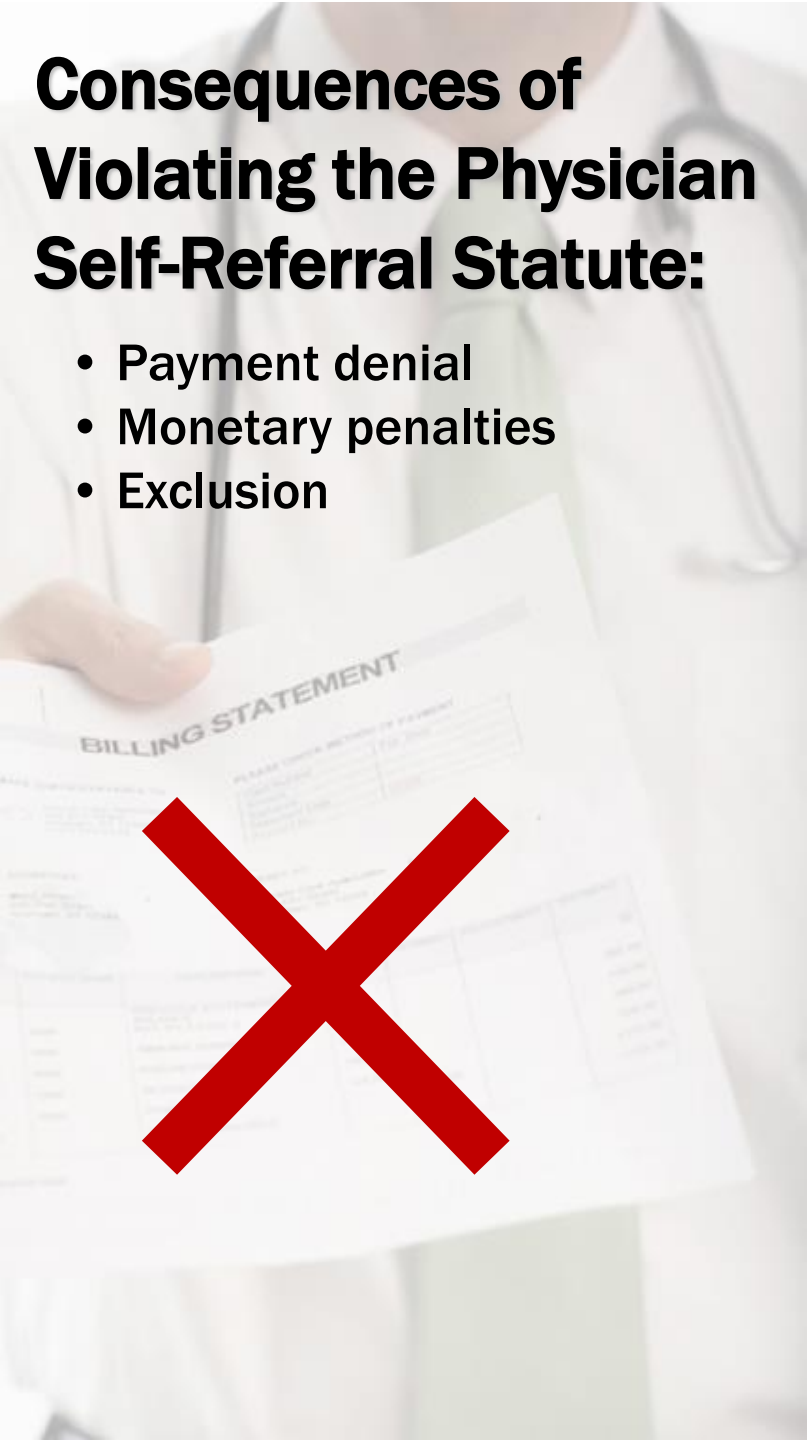
Prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities **with which the physician or an immediate family member has a financial relationship**, unless an exception applies.

- Financial relationships include both ownership/investment interests and compensation arrangements.
  - **For example:** If you invest in an imaging center, the Stark law requires the resulting financial relationship to fit within an exception or you may not refer patients to the facility and the entity may not bill for the referred imaging services.

- "designated health services" include clinical laboratory services, physical therapy, and home health services, among others.

Consequences of Violating the Physician Self-Referral Statute:

- Payment denial
- Monetary penalties
- Exclusion



The Physician Self-Referral Statute is a strict liability law, which means proof of **specific intent to violate the law is not required**.

- The entity submitting improper claims is subject to repayment of all amounts received from Medicare and Medicaid that are connected with the improper relationship and may be subject to additional penalties.

- Physicians who violate the law may be subject to monetary penalties as well as exclusion from participation in the Federal health care programs.

- If a referral is made violating the Stark law and payment is received by the entity providing the designated health service, penalties can include **civil penalties up to $15,000 for each unlawful referral**, **exclusion from participation in federal health care programs**, denial of payment for services, refunding of payments received, a **fine of up to $100,000** for each illegal cross-referral arrangement, and **civil penalties up to $10,000 per day for failing to report violations.**

Avoid Violating the Anti-Kickback Statute and Physician Self-Referral Statute by Fitting into a "Safe Harbor" or Exception.

Many arrangements can be structured to avoid the risk of fraud. Additionally, there are "safe harbors" and exceptions to the Anti-Kickback and Stark Laws, but you must meet required every element and condition of the exception to qualify.

For example, a full-time lease agreement between a physician and a provider to whom the physician refers patients can meet the *space rental safe harbor* if the agreement:

- is set out in writing and signed by the parties;
- covers all the premises rented by the parties;
- is for a term not less than 1 year;
- has an aggregate rental charge set in advance, is consistent with fair market value in arm's length transactions, and does not take into account the volume or value of Federal health care program referrals; and,
- the aggregate space rented may not exceed the space that is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

4. Exclusion from Medicare and Medicaid

Healthcare agencies that do business with excluded individuals, entities or partners on these lists may be subject to penalties, fines or civil monetary penalties (CMP) and possible suspensions from participation in government health care programs.

- **Mandatory exclusions**
  - Imposed on the basis of certain criminal convictions.
- **Permissive exclusions**
  - based on sanctions by other agencies, such as a state medical board suspending or revoking a medical license, or other misconduct including defaulting on health education loans or providing unnecessary or substandard care.

Exclusions are handed down by the OIG and last for periods of typically three to five years in most cases before a potential reinstatement may be made.

If you are excluded by OIG from participation in the Federal health care programs, then Medicare, Medicaid, and other Federal health care programs, such as TRICARE and the Veterans Health Administration, will not pay for items or services that you furnish, order, or prescribe. **Excluded physicians may not bill directly for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice.** In addition, if you furnish services to a patient on a private-pay basis, no order or prescription that you give to that patient will be reimbursable by any Federal health care program.

Some refer to exclusion as a "*financial death sentence*" for any health care provider.

Providence's Exclusion Screening Program & Requirements

- In accordance with the Medical Staff Excluded Individual Checks policy, Providence prohibits the credentialing and privileging of Medical Staff members and does not do business with those who are deemed by a Federal and/or State agency as debarred, excluded or otherwise ineligible for participation in federal or state funded health care programs, or who have been convicted of a criminal offense related to health care.
- **All Medical Staff members are screened before hiring or contracting and then monthly thereafter** against the Office of the Inspector General (OIG)'s List of Excluded Individuals and Entities (LEIE) and the General Services Administration (GSA)/System for Award Management (SAM), OFAC-SDN, CMS Preclusion, Medicare Opt Out, **and all State Medicaid exclusion lists** to ensure that none of these persons are excluded or become excluded from participation in federal programs.

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5. Civil Monetary Penalties Law

You should also be aware that OIG may seek civil monetary penalties for a wide variety of abusive conduct, including presenting a claim that is false or fraudulent because it is for a medically unnecessary procedure. OIG also may impose civil monetary penalties for violating the Medicare assignment agreement by overcharging or double billing Medicare beneficiaries.

The adjusted civil penalty amounts for 2025 vary depending on the agency and the type of violation. Here are some examples:

1. **Department of Justice**: The adjusted civil penalties assessed or enforced by components of the Department range from **$7,256 to $84,852** for violations occurring after November 2, 2015.
2. **Federal Election Commission (FEC)**: Violations of federal campaign finance law can result in penalties ranging from **$7,028 to $82,188**.
3. **Department of Labor**: The 2025 civil money penalty amounts for labor-related violations are specified in a table published in the Federal Register.
4. **Executive Office of the President**: The inflation-adjusted penalty amount for 2025 is approximately **$14,308** when rounded to the nearest dollar.

Please note that these amounts apply to *specific violations and agencies*.

Reminder!

No matter your specialty or practice setting, as a physician you may develop relationships with three important groups. Your relationships with these groups will be subject to the provisions of the 5 key fraud and abuse laws.

- **Payers**, like Medicare, Medicaid, patients, and private insurance companies;
- **Other providers**, including physicians and hospitals; and
- **Vendors**, including drug, biologic, and medical device companies.

Future Business Relationships

- ***Colleagues***
- ***Hospitals***
- ***Nursing Homes***
- ***Medical Companies***

Outside Investments

The Office of Inspector General ("OIG") has expressed concern that **physician investments in medical device and distribution entities *should be closely scrutinized under the fraud and abuse laws*.**

- Physicians are frequently approached with investment opportunities in enterprises related to the delivery of health care.
- Sometimes, you are a legitimate source of capital. Other times, you are a source of patient referrals.
- Because the return on an investment sometimes is used to offer kickbacks in exchange for referrals, you should be vigilant when considering health care business opportunities.
- You should send your patients to the provider that, in your medical judgment, can best meet their medical needs.
- Legal counsel may be helpful in understanding the purpose of the business venture and its associated risks.

Is the Arrangement Legitimate?

To avoid violation of the fraud and abuse laws, test the propriety of any proposed engagement by asking yourself the following questions:

- Does the company really need my particular expertise or input?
- Is the venture promising you high rates of return for little or no financial risk?
- Are you being asked to guarantee that you will refer patients or order services from the venture?
- Does the amount of money the company is offering seem fair and appropriate for what it is asking me to do?
- Is it possible the company is paying me for my loyalty so that I will prescribe its drugs or use its devices?

If you want to pursue an industry relationship but are not sure it is legitimate, take steps to learn whether the arrangement is proper.

As a physician, you may have opportunities to consult with or be a promotional speaker for the drug or medical device industry.

***Scrutinize* promotional speaking or consulting opportunities!**

Providence Policy Considerations

PSJH-CPP-718 Vendor/Supplier Interactions

Consulting Arrangements

Speaker's Bureau and Educational Events

PSJH-CPP-719 Gifts, Gratuities, and Business Courtesies

Honoraria/Honorarium and Consultations

Free Drug Samples

If free drug samples are authorized in your clinic by local leadership; there are very specific criteria for use, and there should be a leadership committee at the local level determining if those practices are going to allow to have samples and what policies and procedures govern the sample drug process.

Free drug samples should be used for the purpose of testing for tolerance or titrating dose; they are not to be used as a means to providing financial assistance. Free drug samples should never be commingled with commercial stock drugs.

Medical Directorships & Substantive Responsibility Requirements

Medical Director Agreement Considerations

- **Government Scrutiny**: Given the potential impact on referrals, government agencies closely examine medical director compensation arrangements.
- **Fair Market Value (FMV)**: When establishing medical directorships, it's essential to ensure that compensation is fair and reasonable.
- **Substantive and Well-Defined Roles**: Medical directorships should have clear responsibilities and expectations. These roles should be substantive, meaning they contribute significantly to the organization's functioning.
- **Uniform Contracts**: Consistency in contract terms is crucial. Organizations should use standardized agreements for medical directorships to maintain transparency and fairness.

Physicians can play an important role in ensuring quality of care by serving as medical directors. To be paid to serve as a medical director, you should spend an appropriate amount of time performing necessary services, including:

- actively overseeing clinical care in the facility;
- leading the medical staff to meet the standard of care;
- ensuring proper training, education, and oversight for physicians, nurses and other staff members; and
- identifying and addressing quality problems.

Gift Reporting Requirements

Although some physicians believe that free lunches, subsidized trips, and gifts do not affect their professional judgment, research shows that these types of perquisites and humans' natural desire to reciprocate can influence prescribing practices and generally affect how physicians act.

The Sunshine law requires public disclosure of gifts and limiting the types of gifts physicians may accept. This law ensure that certain activities are conducted openly and ethically, allowing public observation, participation, and access to records.

The Patient Protection and Affordable Care Act of 2010 requires drug, device, and biologic companies to publicly report nearly all gifts or payments they make to physicians since 2013. This information is posted on the Internet so the public will know what gifts and payments a physician receives from industry!

The "Internet test" is important to use in your relationships with the health care industry.
"*How would I feel if this arrangement were trending on the internet*?"

Giving Gifts to Providence Caregivers

Per Providence policy (PSJH-CPP-719 Gifts, Gratuities, and Business Courtesies), directly employed caregivers of Providence are not permitted to accept gifts from independent physicians, even as a *Thank You* or around the holidays. Examples of gifts include:

- *Frequent* meals (breakfast, lunch, dinners)
- Tickets to events/shows
- Gift cards/Certificates/Vouchers
- Gifts that cannot be shared with the department
  - Electronics
  - Jewelry
  - Clothing items/accessories

Providence's Disclosure Program

Reporting Concerns

The purpose of the *Providence Disclosure Program* is to foster a culture of integrity, transparency, and accountability within our family of organizations. This program is designed to support the identification, correction, and prevention of compliance and quality issues, helping ensure the highest standards of ethical and legal conduct and patient care. It aims to empower all workforce members to speak up and report compliance and quality of care related issues and concerns confidentially and without fear of retaliation. *PSJH-CPP-741 Disclosure Program*

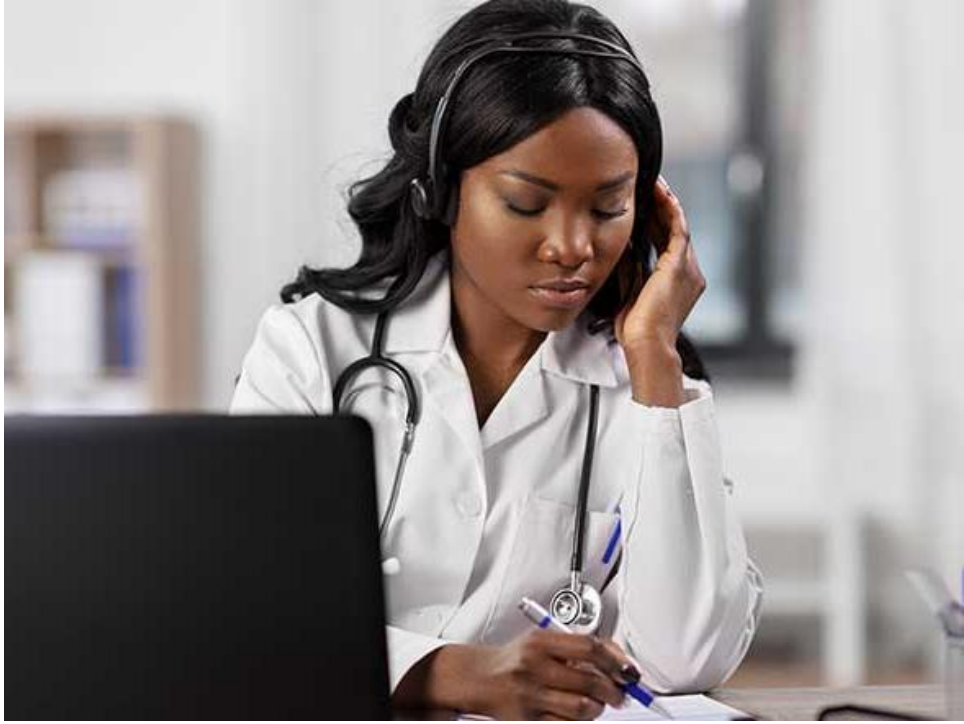
Integrity Hotline

1-888-294-8455

High Reliability Platform (HRP)

Found in the My Apps portal via Providence network. Must be on Providence network to create a report.

More Ways to Report FWA Concerns



You can also report suspected cases of fraud, waste, or abuse in Federal HHS programs with the U.S. Department of Health and Human Services, Office of Inspector General electronically through the Office of Inspector General's Complaint Portal, available at https://oig.hhs.gov/fraud/report-fraud/index.asp, or by mail or phone at:

U.S. Department of Health and Human Services, Office of Inspector General, ATTN: OIG HOTLINE OPERATIONS, P.O. Box 23489, Washington, DC 20026.

Phone: 1-800-HHS-TIPS (1-800-447-8477) or 1-800-377-4950 (TTY)

Privacy Compliance at Providence

- **Mission and Values:** Privacy is about respecting individuals - Safeguarding information is the "right thing to do" and our patients expect it
- **Legal and Regulatory:** The risk of civil monetary penalties and litigation is reduced when we comply with privacy requirements
- **Quality of Care:** Patient confidence in privacy promotes communication/ transparency for higher quality of care
- **Reputation and Viability:** Privacy creates an environment of trust for our patients

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Know the 18 Patient Identifiers

1. Names
2. Geographic subdivisions smaller than a state (address, zip code, etc.)
3. All elements of dates (birth date, admission date, discharge date, date of death)
4. Telephone Number
5. Fax numbers
6. E-mail address
7. Social security numbers
8. Medical record numbers
9. Health plan numbers
10. Account numbers
11. Certificate/License number
12. Vehicle numbers
13. Device identifiers and serial numbers
14. Web Universal Resource Locators (URL)
15. Internet Protocol (IP)
16. Biometric Identifiers (fingerprint, voice)
17. Full face photographic images and any comparable images (tattoos)
18. Any other unique identifying number, characteristic, or code (unique pictures with elements known to patient)

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Using PHI for Treatment

You may use and disclose PHI to provide the patient with appropriate treatment and may disclose PHI to other health care providers that have a care relationship with the patient—includes nurses, labs, technicians, etc.

PHI **may not** be shared or spoken with providers who are **not involved** with the patient's care.

The use of personal devices to take or share pictures or videos with other caregivers is prohibited even if the image is believed to be de-identified.

A former care relationship, curiosity, or personal relationship, **does not always** qualify as involved with the patient's care.

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Examples of Sharing with Others

A physician may use discretion and discuss a patient's treatment in front of the patient's friend if the patient asks that her friend come into the treatment room.

A physician may discuss the after care plans with a patient with an individual who has accompanied the patient to a medical appointment. The information must be "need to know" for the person supporting the patient.

A physician may give information about a patient's mobility limitations to the patient's sister who is driving the patient home from the hospital.

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Examples of Sharing When the Patient Cannot Authorize

A surgeon who did emergency surgery on a patient may tell the patient's spouse about the patient's condition while the patient is unconscious.

A pharmacist may give a prescription to a patient's friend who the patient has sent to pick up the prescription.

A health care provider may give information regarding a patient's drug dosage to the patient's health aide who calls the provider with questions about a prescription.

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Access to EPIC and Other Information Systems

Access is granted based on job role

Access is monitored and recorded 24/7

You may not view **your own record**, or information of family members, friends, neighbors, or co-workers

Inappropriate access, use, or disclosure will result in corrective action up to and including termination

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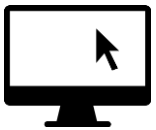
Impermissible Uses of EPIC

 Using *any part* of the Electronic Health Record (EHR) to view a patient's record including their name and/or address only without a Providence business reason. The fact that an individual is/was a patient is protected health information. Follow query procedures to avoid accessing the wrong record.	*Includes birthdays, addresses, etc. even when asked by co-worker, family, etc.*
 Searching, monitoring, accessing medical information for purposes of curiosity/concern.	*Includes co-worker, person of interest (people in the news, celebrities, etc.), family member, etc. This includes viewing census or ED status boards when doing so is not part of your job role.*
 Using census boards/track boards, appointment desk, or other modules in the EHR outside your job role.	*Monitoring for admissions to your unit when this is not your role; making appointments for family, self or friends, locating them in hospital, checking ED wait times, etc.*

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Impermissible Uses of EPIC (cont.)

 Using patient chart for training purposes.	*Includes co-worker charts, even with their permission.*
 Circumventing ROI/HIM processes to obtain copies of medical records for self or others.	*Including records needed for litigation, research, etc.*
 Sharing credentials or not logging off before workstation is used by another user.	*Utilize the IT Service Desk. You are responsible for all access made under your user credentials – protect them!*

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Privacy and Patient Rights Safeguards: *What Should You Do?*

Verify patient identity by using 3 identifiers. Many patients share full names and dates of birth and errors cause significant billing issues for patients along with privacy concerns.

Be cautious with verbal conversations whether in treatment areas or in public areas. Know the audience listening.

Escalate *all requests* by patients promptly to avoid missing legal deadlines (i.e.; requests for medical record access or changes to medical records).

Keep all papers with PHI (minimize) out of view of the public and dispose of properly (clinic sign in sheets).

Always use a fax coversheet.

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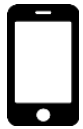
Security Safeguards: *What Should You Do?*



Store portable devices and other electronic media in a secure location—*your car is not a secure location*!

Never download confidential information onto a home or non-Providence device.

Only use your Providence email account—never use a personal email account to send assignments or other Providence related work product.

Secure your computer, voicemail and other passwords—lock and don't share!

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It’s Not Just PHI

In addition to PHI, you are expected to protect Confidential Information, which includes:

- Employee/Personnel information (includes, students, residents, volunteers)
- Employee Health information
- Business operations not available to the public
- Board, Medical Staff Committee, etc. meeting minutes, notes or actions
- Trade secrets or other confidential information/processes
- Privileged information from internal/external counsel

Removing confidential information requires supervisor/manager approval.

Be aware of security configurations in repositories.

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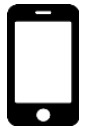
Texting Guidelines



Do not text PHI. Utilize approved communication methods (Teams, Outlook, Epic In basket).

If you must text in an emergency situation, request a phone call back or keep it generic.

If you receive confidential information on your cell phone report it but do not share it.

Centers for Medicare and Medicaid Services (CMS) does not permit the texting of orders by physicians or other health care providers

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Responsible Use of Social Media

Never use personal devices to take photos or record in patient care areas. A doctor using a personal device in a patient care area to capture images that seemingly do not identify a patient is still a violation of policy. If you see others doing this report it immediately!

Never post textual descriptions of anything related to the care or treatment of a patient on your personal social media account. A unique story that you think is de-identified may be identifiable to a patient or their family. Marketing or Communications must review and approve all intended disclosures of patient information outside of Providence. Verbal permission is not sufficient.

Never share confidential or proprietary information about Providence or other workforce members even when your account is set to private. If you identify yourself on your personal social media account as a workforce member at Providence, you should make it clear that your statements and opinions are yours and are not being made on behalf of Providence.

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Media Requests

- If contacted by a reporter or the media about a patient, you should notify a Providence core leader or the house supervisor (politely declining requests for information).
- Only designated individuals within Providence are authorized as public spokespeople to speak with the media.
- The media should never be permitted within patient care areas and are treated as general visitors to the hospital (unless appropriately authorized by senior leadership) and appropriate patient consents and authorizations are in place.

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Cyber Security at Providence

- Providence monitors the use of all information systems, all access to electronic data, and all devices that are used to access our systems or data.
- Personal device use must comply with all security policies (password protected, updated Operating System, patches, anti-virus, etc.) and the Use of Personal Device HR policy.
- Personal devices that contain Providence applications, programs, and apps are not to be used by anyone else or shared with anyone else.
- Any attempt to circumvent Providence security controls or non-compliance with policies can result in disciplinary action up to including termination of contract/partnership.

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Cyber Security Best Practices

- Keep all passwords private and secure. Do not share with anyone, **ever**!
- Lock or log off your computer when you walk away.
- Texting is not secure. If you must text PHI in an emergency, only provide the *minimum necessary*.
  - Centers for Medicaid and Medicare Services (CMS) has stated that physicians cannot create/share patient orders over text message, even in an emergency.
- To avoid phishing schemes, work related or personal, do no click on suspicious links or download attachments from unfamiliar senders, especially from email addresses you've never encountered before.

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Health Connect Partners, LLC
MSSP ACO Integrity & Compliance Training

2025

Why Do I Need ACO Compliance Training?

Why do I need ACO compliance training?

- Compliance training is required by CMS for all MSSP ACOs – including employees, providers, and suppliers
- Your organization has chosen to participate in the HCP MSSP ACO. This means that *you* are now participating in the MSSP ACO too
- There are a few things you need to know to help ensure HCP complies with CMS requirements

What Am I Going to Learn and Is It Important?

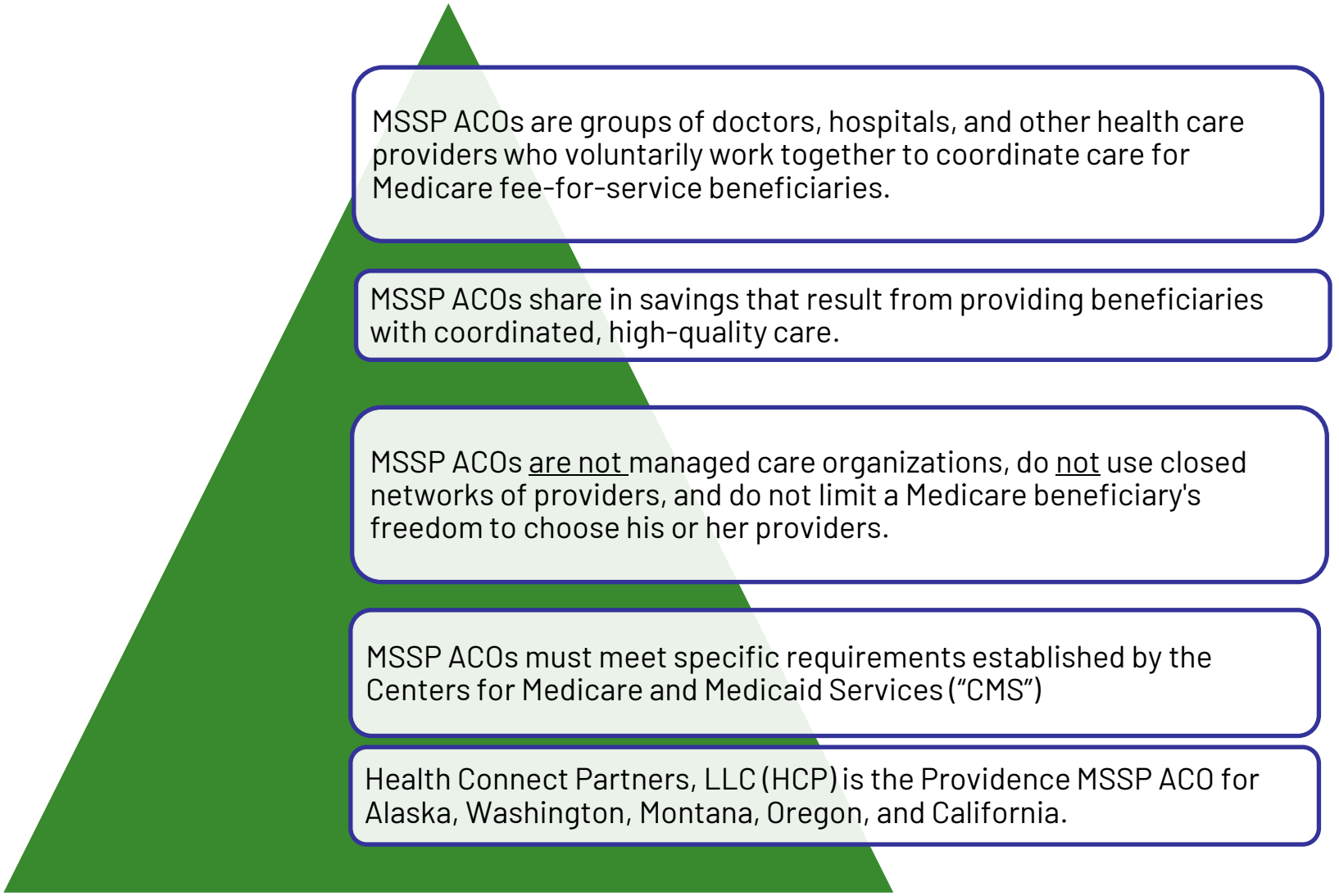
This compliance training program will address:

- Specific compliance requirements of MSSP ACOs
- Compliance issues, including fraud, waste, and abuse
- HCP's Integrity & Compliance Program
- Who to contact with questions or concerns

Compliance training is important, non-compliance can be very serious and result in:

- Termination of HCP's contract with CMS
- Loss of substantial amounts of funding
- Possible civil and/or criminal penalties for serious or intentional violations

What is a Medicare Shared Savings Program ("MSSP") Accountable Care Organization ("ACO")?



MSSP ACOs are groups of doctors, hospitals, and other health care providers who voluntarily work together to coordinate care for Medicare fee-for-service beneficiaries.

MSSP ACOs share in savings that result from providing beneficiaries with coordinated, high-quality care.

MSSP ACOs are not managed care organizations, do not use closed networks of providers, and do not limit a Medicare beneficiary's freedom to choose his or her providers.

MSSP ACOs must meet specific requirements established by the Centers for Medicare and Medicaid Services ("CMS")

Health Connect Partners, LLC (HCP) is the Providence MSSP ACO for Alaska, Washington, Montana, Oregon, and California.

MSSP ACO Compliance Requirements

CMS has established specific compliance requirements for all MSSP participants that go beyond those that otherwise apply to health care providers including:

- Medically necessary and appropriate care
- At-risk beneficiaries
- Beneficiary choice
- Beneficiary notices
- Communications with beneficiaries
- Marketing materials
- Gifts to beneficiaries
- Other MSSP requirements

Let's look at each of these areas further

Medically Necessary and Appropriate Care

- Your MSSP ACO is committed to achieving the goals of:
  - Better health
  - Better care
  - Lower costs
- Health care that is **medically necessary** and **appropriate**
- MSSP participants may not:
  - Deny, reduce, or limit medically necessary services
  - Over-utilize services provided to non-MSSP beneficiaries to offset reduced revenues
  - Condition participation in the MSSP ACO on referrals of non-ACO business

At Risk Beneficiaries

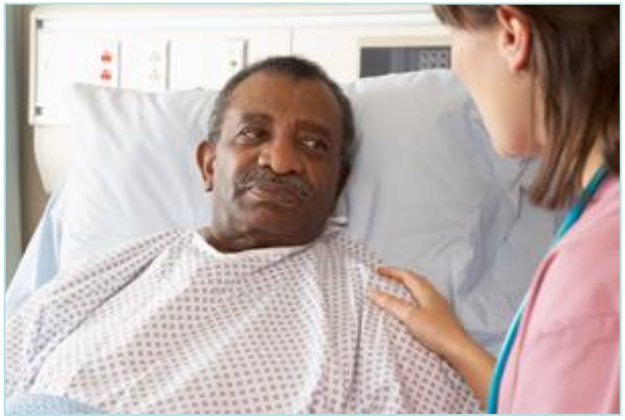
- MSSP participants may not avoid beneficiaries with high-cost medical needs

- An "at risk" beneficiary is a patient who:
  - Has a high CMS risk score on the CMS–HCC risk adjustment model;
  - Is considered high cost due to having two or more hospitalizations or emergency room visits each year
  - Is dually eligible for Medicare and Medicaid;
  - Has a high utilization pattern
  - Has one or more chronic conditions;
  - Has had a recent diagnosis that is expected to result in increased cost;
  - Is entitled to Medicaid because of disability; or
  - is diagnosed with a mental health or substance abuse disorder.

Beneficiary Choice

Can the MSSP ACO limit Medicare beneficiaries to seeing only other ACO providers?

- No – HCP is not a managed care plan or a closed network program.
- Medicare fee-for-service beneficiaries are free to seek care from providers outside of Providence organizations and its affiliate organizations participating in the MSSP ACO.
- MSSP participants may not engage in practices or adopt policies that restrict or limit the right of Medicare fee-for-service beneficiaries to obtain health care services from providers they choose.



Communications with Beneficiaries

Are there other MSSP ACO requirements for communications with Medicare beneficiaries?

Yes – CMS has placed significant limitations on MSSP ACO communications (also referred to as "Marketing Materials") with Medicare beneficiaries:

"Marketing Materials" include
Beneficiary notices
Brochures
Websites
Advertisements
Outreach events
Mailings
Social media

"Marketing Materials" do not include
Billing and claims information
Materials on other specific individual health related issues
Educational materials on health care conditions
Materials customized or limited to a subset of beneficiaries
Materials that do not contain information about the ACO, its participants, or providers
Written referrals for health care services

MSSP ACO Materials – CMS Requirements

- All ACO marketing and communication materials for actual or potential Medicare beneficiaries require advance approval by CMS
- ACOs are prohibited from using incorrect or misleading information in marketing materials
- ACOs may not modify template marketing materials provided by CMS without approval of CMS
- Medicare and ACO contact information must be included in all materials developed or distributed to Medicare beneficiaries
- CMS prohibits the use of certain specific language, phrases, and terms in MSSP ACO marketing materials

MSSP ACO Materials – CMS Requirements

ACO-created materials may not contain:

- Language suggesting beneficiaries are required to see only ACO providers, or are in any way prohibited from seeing providers outside the ACO
- Language suggesting beneficiaries enroll or are participating in ACOs; wording should be clear the provider, not the beneficiary, has chosen to participate in the ACO
- Language suggesting CMS endorses one ACO over another
- Language suggesting an ACO is in any way superior to other ACOs, or other types of ACOs, or that providers participating in the ACO are superior to other providers participating in other ACOs or CMS initiatives

MSSP ACO Materials – CMS Requirements

CMS prohibits the use of certain terms and phrases in ACO-created materials:

Prohibited	CMS Suggested Alternative
"Managed care" or "care management"	"Coordinated care" or "care coordination"
Beneficiaries "enroll" or "enrollment"	Providers "participate"
"You have been selected to participate"	"Your provider has chosen to participate"

Refer to CMS' *Guidelines for MSSP ACO Marketing Materials* for additional information

MSSP ACO Materials – CMS Requirements Beneficiary Notifications

- **Initial Notification:** MSSP ACOs must provide beneficiaries with a Beneficiary Notification Letter at or before their first primary care visit of the year for each five-year agreement period. Any new beneficiaries added throughout the agreement period will also need the initial Beneficiary Notification.

- **Follow-Up Notification:** MSSP ACOs must also furnish a follow--up communication at the beneficiary's next primary care visit or within 180 -days of the beneficiary receiving the first notification. This notification is intended to provide the beneficiary with a meaningful opportunity to ask any outstanding questions they might have and serve as a tool to reduce beneficiary confusion and increase comprehension of the ACO program and cannot be simply resending the first notification.

- **Signage:** **All** MSSP ACO facilities must post the current CMS MSSP Poster in an area viewable to patients.

- **Templates:** CMS provides templates that must be used for notifications and signage and may not be altered.

Gifts to Beneficiaries

Can an MSSP ACO participant offer free or discounted services to Medicare beneficiaries?

Yes – but strict limitations apply. Organizations are allowed to provide Medicare beneficiaries free or below market value items and services to encourage care coordination and beneficiary health awareness when it meets all of the following requirements:

- "In-kind" (e.g. goods, commodities, and services, but not cash);
- Reasonably connected to the medical care of the beneficiary;
- Either preventive care items or services or intended to advance one or more of the following clinical goals:
  - Adherence to a treatment regime
  - Adherence to a follow-up care plan; and/or
  - Management of a chronic disease or condition
- Not a Medicare covered item or service.

Gifts to Beneficiaries

MSSP ACO participants may not give Medicare beneficiaries:

- Cash or items unrelated to health care under any circumstances (e.g. sporting event tickets, gift certificates for non-health care items)
- Items or services as a reward for receiving services from the organization
- Items or services to persuade a Medicare beneficiary to remain in the ACO or with a particular ACO provider

Appropriate	Inappropriate
An ACO may provide a blood pressure monitor to a patient with hypertension to encourage regular blood pressure monitoring	An ACO may not waive or reduce Medicare copayments or deductibles unless based on a beneficiary's financial need. This would be considered a financial incentive, not "in-kind" goods and services

Other MSSP ACO Requirements

MSSP ACO participants must also adhere to additional requirements of the MSSP ACO program including:

- Development of processes supporting evidence-based medicine, quality assurance, and patient engagement
- Periodic submission of quality data, certifications, and other information in accordance with CMS requirements
- Retention of all records related to MSSP for a minimum of 10 years after the ACO agreement period ends

All HCP participant organizations are expected to cooperate in the gathering, recording, and submitting of data in a timely, accurate, and complete manner, and assist in meeting all other requirements

Seeking Answers to Your Questions

- All HCP participants are encouraged to seek answers to questions and report issues and concerns

- HCP participants are expected to report, in good faith, any actual or suspected fraud, waste, and abuse, violations of law or regulations, or MSSP policies

- You may choose one or more of the following options for reporting:
  - *A manager, supervisor, or compliance officer in your organization*
  - *MSSP ACO Compliance Officer (Amy Riedel): amy.riedel@providence.org*
  - *Providence Compliance Hotline: 888-294-8455*

Completion Attestation

STOP!

To be marked complete for reviewing this education, please fill out the Education Attestation. It will take less than 3 minutes of your time.

There is an option to have a Certificate of Completion sent to your email of choice.

Next slide contains instructions on how to obtain CMEs for this education.

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CME Evaluation and Claiming Credit

In order to obtain your credits/certificate for this Swedish CME activity, you will need to complete the course evaluation using the web address or QR code below. The final page of the evaluation will have a link to claim your credit.

https://forms.office.com/r/qU1PmNcqWQ

The maximum number of credit hours for this activity is 1.0. Your certificate will auto-populate after you submit your hours. Print, email or save your certificate *(you may need to have pop-ups enabled on your browser).*

Questions? Email cme@swedish.org

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