



Accountable Care Organization (ACO) Specific Compliance Training

2026

Course Introduction | Purpose

The Purpose

The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Shared Savings Program Accountable Care Organizations (MSSP ACOs) to provide compliance training to their employees and to participating providers and suppliers. The purpose of this training is to supplement Privia's standard compliance training and discuss specific requirements related to participation in the Medicare Shared Savings Program.

NOTE: For ACO participants who are not members of Privia Medical Group, this training is intended to supplement your practice's standard compliance training.

Course Introduction | Objectives

Upon completion, you will be able to:

- 1 Explain the purpose of an MSSP ACO.
- 2 Define key MSSP ACO requirements.
- 3 Describe your role in meeting MSSP ACO requirements.



ACO Specific Compliance Training

Intro to the MSSP ACO

What is the Medicare Shared Savings Program Accountable Care Organization?

The Medicare Shared Savings Program is an important innovation designed to shift CMS' payment system from a volume-based approach to one focused on value and outcomes.

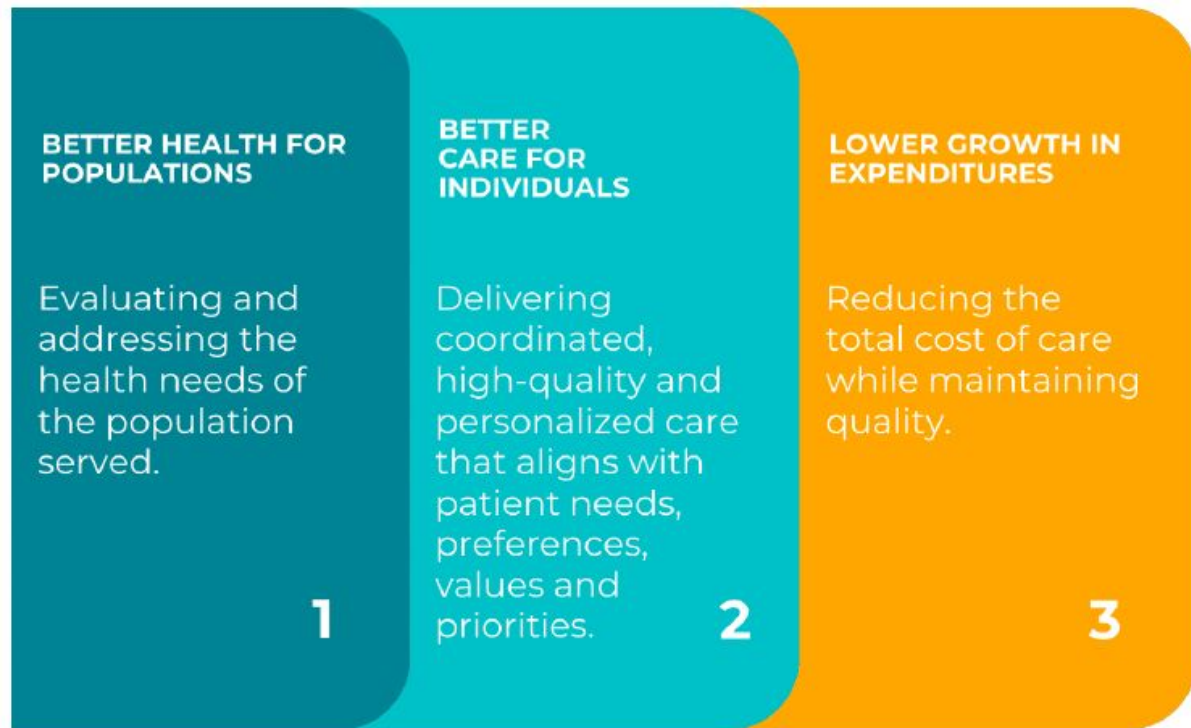
The MSSP achieves this by:

- Promoting accountability for a patient population.
- Coordinating the delivery of items and services for Medicare FFS beneficiaries.
- Encourages investments in services that are both high quality and efficient.

Accountable Care Organizations (ACOs) are groups of healthcare providers participating in the Medicare Shared Savings Program. Their goal is to provide coordinated, high-quality care to Medicare patients, improving quality and reducing unnecessary spending. Successful ACOs can earn performance payments, which represent a share of the savings they generate for Medicare.

Three-Part Goals of the MSSP ACO Program

The three-part goals of the MSSP ACO Program are:



NOTE: ACOs are not managed care organizations or closed provider networks and do not limit a Medicare beneficiary's free choice of providers.

Why You Need to Take MSSP ACO Compliance Training

Privia has chosen to participate in the Medicare Shared Savings Program, which means we are part of an ACO. If you bill Medicare under the Tax Identification Number belonging to an ACO participant, you are an ACO provider and need to understand some of the specific regulatory requirements of ACOs. Additionally, those who oversee ACO participant decision-making also need to understand these requirements.

This course is designed to reinforce your understanding of MSSP ACO compliance and program requirements, reflecting our commitment to adhering to all applicable MSSP and federal healthcare program laws and regulations.

Consequences of Non-Compliance

The consequences of noncompliance with CMS requirements are very serious and can result in termination from participation in the MSSP, repayment of substantial amounts of funding, and civil and/or criminal penalties for serious violations.



ACO Specific Compliance Training

MSSP ACO Program Requirements

MSSP ACO Program Requirements

CMS has established specific program requirements that are unique to MSSP ACOs addressing areas such as:

- Medically necessary and appropriate care
- At-risk beneficiaries
- Beneficiary referrals
- Marketing communications
- Benefit enhancements
- Beneficiary in-kind health incentives
- Beneficiary notifications

Medically Necessary and Appropriate Care

Privia's MSSP ACO is committed to achieving the goals of better health, better care, and lower costs. This goal is achieved by providing high quality, cost-effective health care to Medicare beneficiaries that is both medically necessary and appropriate.

MSSP ACOs may not deny, reduce, or limit medically necessary services or treatment or engage in any practice or activity that would reasonably be expected to deny or discourage providing medically necessary services to Medicare patients. CMS monitors claims data to ensure ACOs comply with these requirements.



At-Risk Beneficiaries

MSSP ACOs are prohibited from avoiding higher cost or at-risk Medicare beneficiaries assigned to them in order to keep costs low.

An “at-risk” beneficiary is a patient who:

- Has a CMS high-risk score
- Has one or more chronic conditions
- Is dually eligible for Medicare and Medicaid
- Is entitled to Medicare because of a disability
- Is diagnosed with a mental health or substance abuse disorder
- Has had a recent diagnosis that is expected to result in increased cost
- Has had two or more hospitalizations or emergency room visits each year
- Has a high health care utilization pattern

These patients, however, may appropriately be identified by the ACO in order to better coordinate and deliver their care more efficiently and improve their health.

The regulatory consequences of avoiding at-risk beneficiaries may include CMS taking pre-termination actions or immediately terminating an ACO if it's determined the ACO, its ACO participants, providers, suppliers or any other individual or entity performing functions or services related to ACO activities avoids at-risk beneficiaries.



Beneficiary Referrals

MSSP ACOs may not condition the participation of ACO participants or providers/suppliers on referrals of Federal health care program business that the individual knew or should have known is being (or would be) provided to Beneficiaries who are not assigned to the ACO.

MSSP ACOs may not require that beneficiaries be referred only to ACO participants or ACO providers/suppliers within the ACO or to any other provider or supplier, except when:

- The beneficiary expresses a preference for a different provider, practitioner or supplier; or
- The referral is not in the beneficiary's best medical interests in the judgment of the referring party.

Beneficiary Referrals Cont.



Can MSSP ACOs require or otherwise limit Medicare beneficiaries to seeing only ACO providers or suppliers?

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NO!

Medicare beneficiaries are free to seek care from providers outside of Privia's MSSP ACO network.

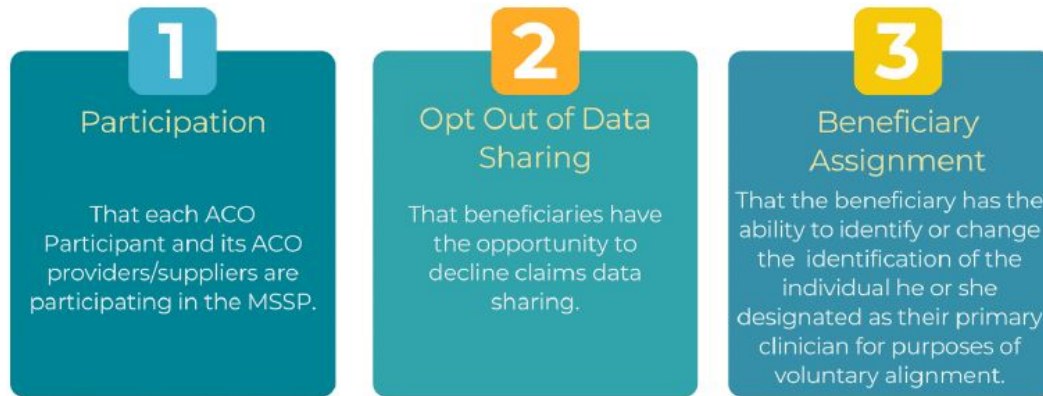


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MSSP ACOs may encourage the use of ACO participating providers as well as communicate the benefit of receiving coordinated quality care from network providers and suppliers.

Beneficiary Notification

The beneficiary notification must be provided at least once to all traditional Medicare beneficiaries before or at the first primary care visit of the agreement period. Follow-up communication to the beneficiary must be sent no later than 180 days from the date the initial written notice was provided. The initial and follow-up communication should be documented in athena or your applicable EHR; documentation must be made available to CMS and/or the ACO Compliance Officer upon request. ACO Participants must post the appropriate signage in all of its facilities and make the written notification available to beneficiaries upon request in settings where beneficiaries receive primary care services.



Beneficiary Notification Cont.

1

Participation

That each ACO Participant and its ACO providers/suppliers are participating in the MSSP.

2

Opt Out of Data Sharing

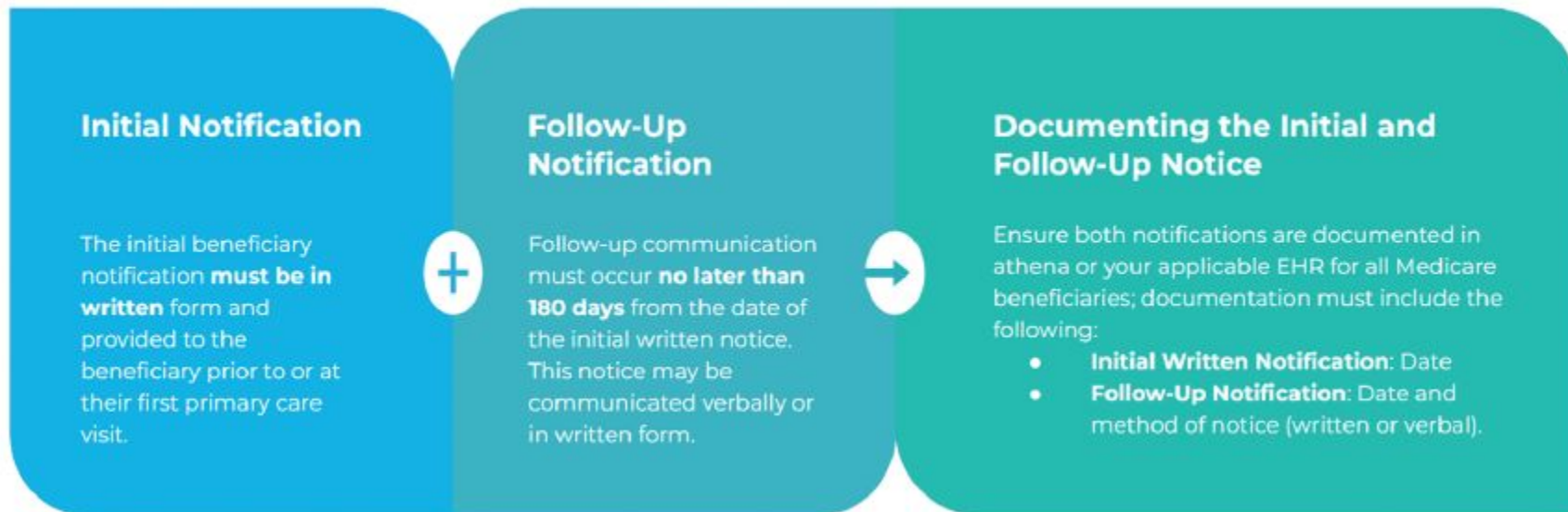
That beneficiaries have the opportunity to decline claims data sharing.

3

Beneficiary Assignment

That the beneficiary has the ability to identify or change the identification of the individual he or she designated as their primary clinician for purposes of voluntary alignment.

Beneficiary Notification Cont.



Marketing Communications: What are Marketing Materials?

Marketing materials and activities are general audience materials used to educate, solicit, notify, or contact Medicare beneficiaries or providers and suppliers regarding the Shared Savings Program. These communications include:

- Brochures
- Advertisements
- Letters to beneficiaries
- Outreach events
- Web pages
- Data sharing opt-out letters
- Mailings
- Social media, or other activities conducted by or on behalf of the ACO, or by ACO participants, or ACO providers/suppliers participating in the ACO.

Marketing Communications Cont.

Examples of Communications that are NOT Marketing Materials

- Certain informational materials customized or limited to a subset of beneficiaries;
- Materials that do not include information about the ACO, its ACO participants, or its ACO providers/suppliers;
- Materials that cover beneficiary-specific billing and claims issues or other specific individual health related issues;
- Educational information on specific medical conditions (e.g. flu shot reminders),
- Written referrals for health care items and services.

Note: All marketing materials and activities must be retained according to record retention requirements.

Marketing Communications: Compliance with Marketing Materials and Activities

In order to prevent MSSP employees and participants from seeking to attract or avoid beneficiaries with certain health profiles, and to guard against beneficiary confusion, MSSP ACO communications with beneficiaries are regulated.

MSSP ACOs may not use inaccurate or misleading information in communications or marketing activities such as brochures, websites, advertisements, outreach events, mailings, and social media.



Marketing Communications: Compliance with Marketing Materials and Activities Cont.

MSSP ACOs are also prohibited from using marketing materials and activities in a discriminatory manner or for discriminatory purposes.

CMS may request the submission of marketing materials and activities at any time. If CMS determines that the marketing materials and activities do not comply with requirements, CMS will issue a written notice of disapproval to the ACO. The ACO must discontinue and require its ACO Participants, ACO providers/suppliers, and other individuals or entities to discontinue the use of any marketing materials or activities disapproved by CMS.



Marketing Material Approval

Marketing materials must be approved by the ACO Compliance Officer and Marketing Team. If your role or responsibilities involve communications or marketing activities with Medicare beneficiaries, please contact Privia's Marketing Team for assistance. You may also contact the ACO Compliance Officer if you have any questions or concerns with marketing materials or activities.

Benefit Enhancements

Benefit enhancements are conditional waivers of certain payment rules or other Medicare requirements to support the Shared Savings Program. These enhancements include the Skilled Nursing Facility (SNF) 3-Day rule and telehealth services.



Benefit Enhancements Cont.

SNF 3-Day Rule

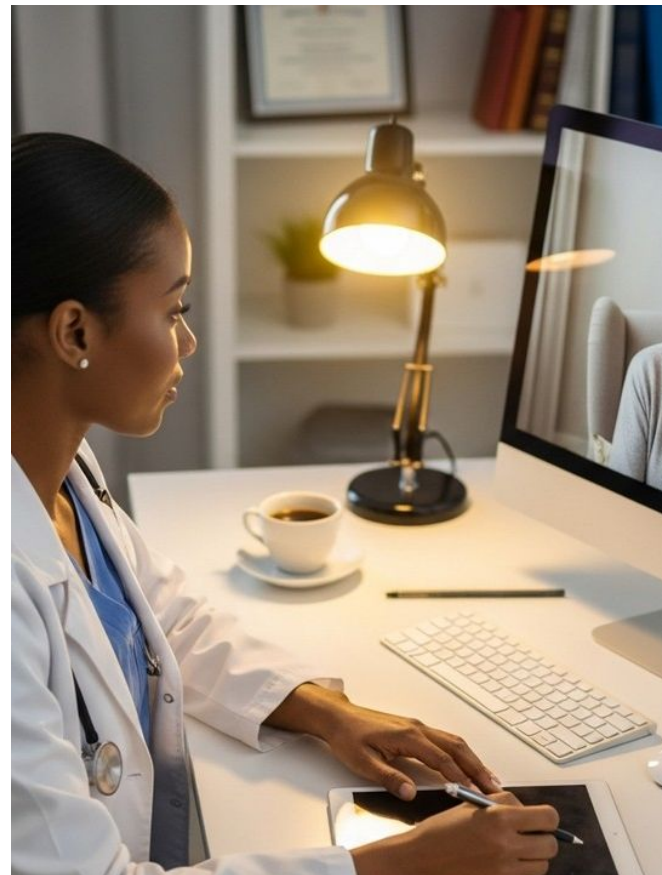
The SNF 3-Day rule waives the requirement for a 3-day inpatient hospital stay prior to a SNF admission for eligible beneficiaries assigned to ACOs participating in a two-sided risk model. This waiver supports the ACO's efforts to increase quality and decrease costs. Eligible ACOs must submit an application to CMS in accordance with CMS requirements.

Originating Site Requirements

CMS also waived originating site requirements (geographic restrictions), for applicable ACOs, allowing Medicare beneficiaries to receive many telehealth services from their home. Providers in applicable ACOs may provide and receive payment for covered telehealth services, without geographic restrictions, provided certain conditions are met.

Benefit Enhancements Cont.

Contact your ACO Compliance Officer if you have questions about which benefit enhancements are available in your MSSP ACO and to receive additional training, as appropriate, if your responsibilities include ensuring compliance with benefit enhancement requirements.



Beneficiary Inducements and In-Kind Health Incentives

MSSP ACOs are prohibited from providing gifts or other remuneration to beneficiaries as inducements for receiving items or services from or remaining in, an ACO or with ACO providers/suppliers in a particular ACO or receiving items or services from ACO participants or ACO providers/suppliers.

CMS allows MSSP ACOs to provide free or discounted items and services to Medicare beneficiaries as incentives to promote their health and wellness. Beneficiary incentives must be in-kind in nature, meaning they must be in the form of items or services and meet CMS criteria.

Beneficiary Inducements and In-Kind Health Incentives Cont.

In-kind items or services:

- Must be reasonably connected to the medical care of the beneficiary.
- Must not be a Medicare-covered item or service for the beneficiary on the date the in-kind item or service is provided to the beneficiary, including services that could be covered by a Benefit Enhancement.
- Must be either preventative care items or services or advance a clinical goal for the beneficiary.

An example of an appropriate beneficiary incentive is providing a blood pressure monitor for a patient with hypertension.



Do not distribute any incentives to Medicare beneficiaries without first gaining the approval of your Privia ACO Compliance Officer.

Note: For approval, please contact Privia's ACO Compliance Officer Stephanie Clark.
stephanie.clark@priviahealth.com

Medicare Revalidation for ACO Participants and Participant Groups

Maintain TIN Level Validation

ACO Participants and participant groups must maintain TIN level validation with Medicare in the Provider Enrollment, Chain, and Ownership System (PECOS) to ensure your legacy data is aligned in the MSSP ACO.

CMS Revalidation Alerts

You will receive a revalidation notice from your enrollment contractor via email or U.S. postal mail about three to four months prior to your due date.

Medicare Revalidation Lookup

The Medicare Revalidation List is a searchable database that allows you to look up the due date for Medicare providers or organization who must revalidate their enrollment record information every three to five years. CMS publishes revalidation due dates seven months in advance.

Revalidation Links

PECOS: <https://pecos.cms.hhs.gov>

Medicare Revalidation Lookup:
data.cms.gov/tools/medicare-revalidation-list



Revalidate Online Using PECOS

PECOS is the most efficient way to submit your revalidation; PECOS allows you to:

1. Review information currently on file.
2. Upload supporting documents.
3. Electronically sign and submit your revalidation online.

Best Practice: PECOS Administrator

We recommend each practice/group designate a PECOS Administrator to track and maintain TIN revalidation requirements to ensure your TIN remains appropriately enrolled in Medicare.

Other Requirements

In addition to the areas we have covered, MSSP ACOs are also subject to the following:

REQUIRED PROCESSES

MSSP ACOs must develop process that support:

- Evidence Based Medicine
- Internal Reporting on Cost and Quality
- Patient Engagement
- Care Coordination

DATA SUBMISSION

You might be asked to periodically assist in the gathering, recording and submission of data/information to your ACO and CMS (e.g. quality data, certifications).

RECORD RETENTION

MSSP ACOs are required to keep all records for at least 10 years after the ACO agreement period ends or from the date of completion of any audit, evaluation, or inspection whichever is later, unless CMS specifies otherwise.



ACO Specific Compliance Training

MSSP ACO Compliance Program Requirements

MSSP ACO Compliance Requirements

CMS has established specific compliance program requirements for MSSP ACOs that address areas such as the ACO compliance plan, an effective compliance program, data requirements, compliance with privacy and security rules, reporting compliance issues, and reporting to law enforcement agencies. In this module, we will go through each of these requirements.

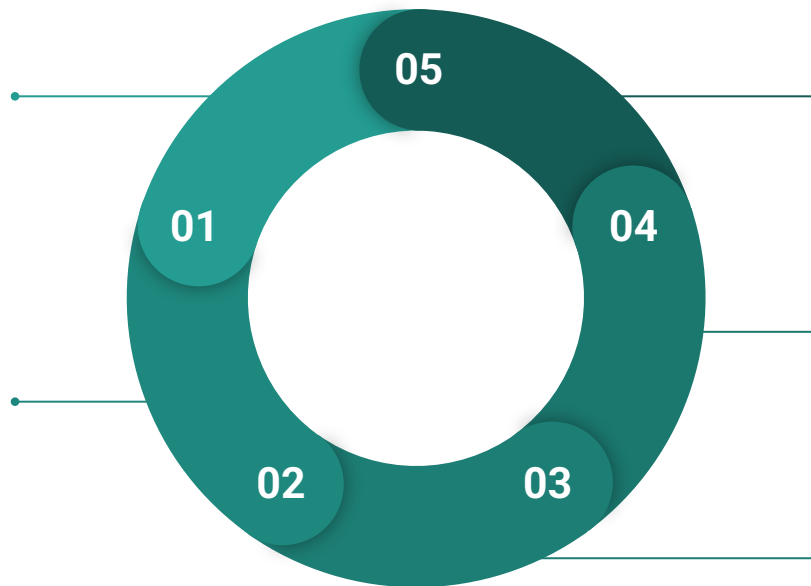
MSSP Compliance Plan Requirement

Compliance Officer

A designated compliance official who is not legal counsel to the ACO and reports directly to the ACO's Governing Body.

Mechanisms for Identifying and Addressing issues

Mechanisms for identifying and addressing compliance problems related to ACO operations and performance.



Reporting Violations to the Law

A requirement for the ACO to report probable violations of the law to an appropriate law enforcement agency.

Compliance Training

Compliance training for the ACO, ACO participants, and ACO providers/suppliers.

Anonymous Reporting Methods

A method for employees or contractors of the ACO, ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities to anonymously report suspected problems related to the ACO to the compliance officer.

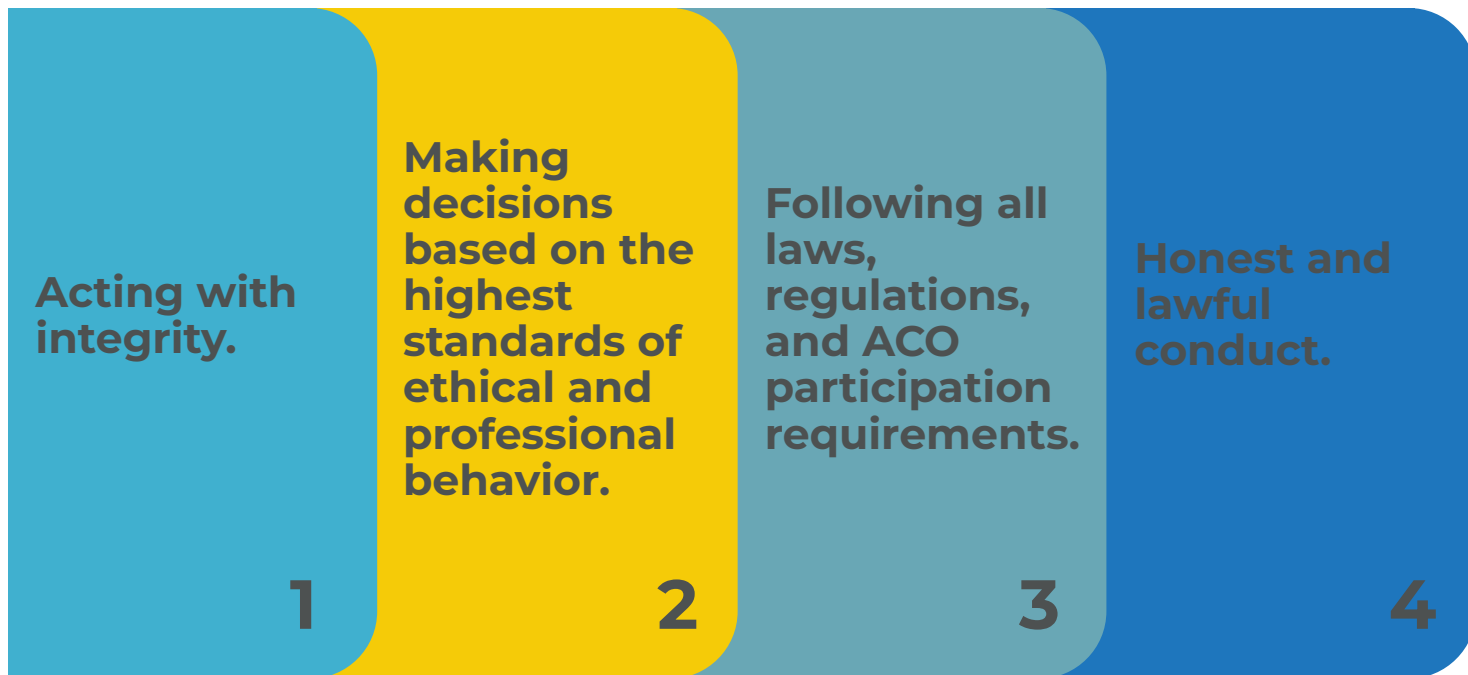
MSSP Compliance Plan Requirement Cont.

Privia's ACO Compliance Plan outlines the components of the ACO's Compliance Program in accordance with these requirements. Our written Compliance Plan is available to all Privia ACO employees, participants, providers and suppliers.

Note: If you have any questions and need a copy of any ACO Compliance Program documents, contact the ACO Compliance Officer at stephanie.clark@priviahealth.com.

ACO Compliance Program Documents and Policies

Your Privia MSSP ACO is committed to:



ACO Compliance Program Documents and Policies Cont.

All ACO Board members, employees, participants, providers, and suppliers are expected to support this commitment.



Conflict of Interest Disclosure

ACOs are mandated by CMS to maintain a conflict of interest policy for their governing body members. This policy requires:

- Each member of the governing body to disclose relevant financial interests.
- A procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise.
- Remedial action for members of the governing body that fail to comply with the policy.

Fiduciary Duty



Governing body members have a fiduciary duty to the ACO, including the duty of loyalty, and must act consistent with that fiduciary duty.

If you have any questions about your ACO's Conflict of Interest Policy, please contact the ACO Compliance Officer at stephanie.clark@priviahealth.com.

Health Insurance Portability and Accountability ACO (HIPAA) Privacy Rule

Privia's MSSP ACOs are required to follow the Health Insurance Portability and Accountability Act (HIPAA). We will discuss the HIPAA Privacy and Security Rules below.

- Requires appropriate safeguards to protect the privacy of Protected Health Information (PHI).
- Sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization.
- Gives patients certain rights over their health information, including the right to examine and obtain a copy of their health records and the right to request amendments.



Business Associate: A person or entity that performs certain functions or activities that require or involve the use or disclosure of protected health information on behalf of, or provides services to, a HIPAA Covered Entity.



Protected Health Information (PHI)

Medicare ACOs are required by federal and state laws to maintain the privacy and security of all protected health information, also known as PHI, received from patients. PHI is individually identifiable health information. Any individually identifiable information counts as protected health information if it relates to an individual's: past, present, or future physical or mental health; their medical history; or their payment for health services.

You are expected to handle PHI in an ethical and responsible manner and to take reasonable measures to protect the confidentiality and security of PHI. PHI must be treated as confidential in all forms, whether on paper, in electronic media, or in verbal discussions. Further, you're obligated to access and use the minimum amount of PHI necessary to do your job.

HIPAA Security Rule & ePHI

The **Security Rule** requires covered entities to maintain reasonable and appropriate administrative, technical, and physical safeguards for protecting ePHI.

Covered entities and business associates must develop and implement reasonable and appropriate security measures through policies and procedures to protect the security of ePHI they create, receive, maintain, or transmit.

Each entity must analyze the risks to ePHI in its environment and create solutions appropriate for its own situation.

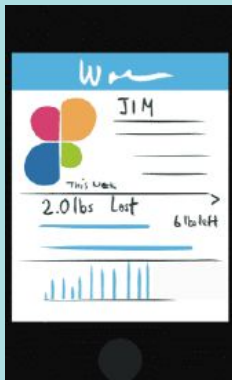


HIPAA Security Rule & ePHI Cont.

ePHI

ePHI is any PHI stored in digital or electronic format such as:

- Electronic Health Records (EHRs)
- Spreadsheets
- Email
- Texts
- Any other electronic or digital form



HHS provides general rules to protect ePHI:

- You must ensure the confidentiality, integrity, and availability of all ePHI created, received, maintained, or transmitted.
- Identify and protect against reasonably anticipated threats to the security or integrity of the information.
- Protect against reasonably anticipated impermissible uses or disclosures.
- Ensure your workforce is compliant.

NOTE: If you experience any incident that compromises the security of PHI or ePHI you must notify Privia's Privacy Team and Privacy Officer via email at privacy@priviahealth.com

CMS Data Use Agreement (DUA)

Annually, before receiving any beneficiary identifiable data from CMS, our ACO's are required to sign a data use agreement. This agreement requires our ACO's to comply with HIPAA, the requirements contained in the DUA, and the statutory and regulatory requirements of the Shared Savings Program.

The data use agreement contains the conditions under which CMS will disclose and the ACO will obtain, use, reuse, and disclose CMS data files. Failure to comply with the data use agreement renders the ACO ineligible to receive data, the ACO may be terminated from the Shared Savings Program and may be subject to additional sanctions and penalties.

NOTE: CMS data may be used without authorization from CMS for clinical treatment, care management and coordination, quality improvement activities, and provider incentive design and implementation; all other uses must comply with the DUA.



Fraud and Abuse Laws

To detect fraud and abuse, you need to know the law. Fraud and Abuse laws are enforced by government agencies, including the Department of Justice, the Department of Health & Human Services/OIG, and CMS.

The five Federal fraud and abuse laws most relevant to Privia Health and its affiliated entities are the False Claims Act, the Anti-Kickback Statute, the Physician Self-Referral Law (also known as the Stark Law), the Exclusion Statute, and the Civil Monetary Penalties Law.

As providers of a Federal health care program, it's important that we understand what constitutes a violation of each Fraud and Abuse law.

Fraud and Abuse Laws Cont.



False Claims Act (FCA)

The FCA protects the Government from being overcharged or sold shoddy goods or services. It is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent. Filing false claims may result in fines of up to three times the program's loss plus \$11,000 per claim filed.



Anti-Kickback Statute (AKS)

AKS is a criminal law that prohibits the knowing and willful payment of remuneration to induce or reward patient referrals of the generation of business involving any item or service payable by the Federal healthcare programs (drugs, supplies, or health care services for Medicare or Medicaid patients). Penalties up to \$50,000 per kickback plus three times the amount of the remuneration.



Physician Self Referral Law

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.



Exclusion Statute

OIG has authority to exclude individuals and entities convicted of: Medicare or Medicaid Fraud, patient abuse or neglect, felony convictions for unlawful manufacture, and distribution, prescription, or dispensing of controlled substances from participation in all Federal healthcare programs.



Exclusion Screenings

All participants must screen its workforce against the OIG, SAM, and all state exclusion lists, prior to hire and monthly thereafter; this includes its employees, volunteers, trainees, students, contractors or any other person or entity performing functions or services on behalf of the participant and/or the participant's care center. Participants are responsible for maintaining documentation substantiating all exclusion checks and resolution of any potential matches.



Civil Monetary Penalties Law

OIG may seek civil monetary penalties and sometimes exclusion for a wide variety of conduct and is authorized to seek different amounts of penalties and assessments based on the type of violation at issue. Penalties range from \$10,000 to \$50,000 per violation.

Methods to Report Suspected or Actual Compliance Issues

You are encouraged to seek the guidance of the ACO Compliance Officer when you have questions or concerns. You may also contact a member of your MSSP ACO's Management Team.

You have a duty to report suspected issues and concerns involving your MSSP ACO. You are expected to report in good faith any actual or suspected fraud, waste, abuse, or violations of laws, regulations, or your MSSP ACO's policies. Failure to report suspected unethical or unlawful conduct is harmful to the integrity of the ACO and is a potential violation of your ACO's compliance plan.

You may also contact:

1. Privia's Compliance Department
2. Privia's Ethics Line via:
 - a. Call
 - b. Text
 - c. Website

Privia's Ethics Line is available 24 hours a day, seven days a week, 365 days a year and you may choose to protect your identity and remain anonymous. All information reported is treated confidentially.

For privacy or security questions or concerns, you may contact the privacy or security office via email; if you wish to remain anonymous, please contact Privia's Ethics Line. Please note that your MSSP ACO prohibits any form of intimidation or retaliation against individuals who report issues and concerns in good faith.

R E P O R T

What

Actual/suspected fraud, waste, and abuse.

Violations of laws or regulations.

Compliance Plan, Code of Conduct, and other Policy violations.

How

The ACO Compliance Officer: stephanie.clark@priviahealth.com

Privia's Chief Audit & Compliance Officer: dana.fields@priviahealth.com

Compliance Office: compliance@priviahealth.com

Each Privia's Employee's Immediate Supervisor

Any Member of Privia's Executive Team or your ACO Management Team

Privia's Legal Department: legal@priviahealth.com

ACO's Confidential & Anonymous Compliance & Ethics Line: 877-851-8048

Privia's Compliance Line Platform: priviahealth.com/ethicsline

Privia's Privacy or Security Department: privacy@priviahealth.com
security@priviahealth.com



Knowledge Check

Question 1

True or False

ACO Participants and participant groups must maintain TIN level Medicare eligibility in PECOS.

- ☐ True
- ☐ False

Question 2

Select all that apply.

Which of the following constitutes an in-kind item or service?

- ☐ An item or service that is preventative in nature or advances a clinical goal.
- ☐ Blood glucose meters
- ☐ Blood pressure reader
- ☐ None of the above

Question 3

Select all that apply.

What documentation should be maintained for ACO Beneficiary Notifications?

- ☐ Initial written notification date
- ☐ Follow-up notification date and method of notice
- ☐ None of the above

Question 4

Select all that apply.

MSSP ACOs are required to develop processes that support which of the following.

- ☐ Care coordination
- ☐ Internal reporting on quality and cost
- ☐ Evidence based medicine
- ☐ Patient engagement
- ☐ None of the above

Question 5

True or False

MSSP ACOs should avoid all beneficiaries who have any of the following:

- ☐ Mental health or substance abuse disorder
- ☐ Two or more emergency visits
- ☐ Multiple hospitalizations
- ☐ A CMS high-risk score

Question 6

Select all that apply.

What are the ways to report compliance issues?

- ☐ Any member of the Executive team, Supervisor or ACO Management Team
- ☐ Report to the Compliance Team via email at compliance@priviahealth.com.
- ☐ Call or text Privia's Ethics Hotline at 877-851-8048 or report via the webform.
- ☐ Contact the ACO Compliance Officer or Privia's Chief Audit and Compliance Officer.

Question 7

True or False

ACO Participants must screen their workforce before hiring and monthly thereafter, against the OIG, List of Excluded Individuals, System for Award Management (SAM), and all State Medicare/Medicaid lists.

- ☐ True
- ☐ False

Question 8

True or False

Which of the following fraud and abuse laws prohibits physicians from referring patients to receive designated health services (DHS) payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies?

- ☐ False Claims Act (FCA)
- ☐ Anti-Kickback Statute (AKS)
- ☐ Physician Self-Referral Law (Stark Law)
- ☐ Civil Monetary Penalties Law

Question 9

Select all that apply.

What benefit enhancements may be offered by an ACO that satisfies CMS eligibility criteria? Select all that apply.

- ☐ SNF 3-Day Rule
- ☐ Beneficiary inducements
- ☐ Waiving originating site requirements for telehealth services
- ☐ Beneficiary referrals

Question 10

Select all that apply.

What are the key requirements of the ACO's Conflict of Interest policy regarding governing body members? Select all that apply.

- ☐ Governing body members must disclose relevant financial interests.
- ☐ A procedure to determine whether a conflict of interest exists and a process to address any conflicts that arise.
- ☐ Remedial action for members of the governing body that do not adhere to the policy.

Knowledge Check Answers

1. True
2. An item or service that is preventative in nature or advances a clinical goal, blood glucose meters, and blood pressure reader
3. Initial written notification date and follow-up notification date and method of notice
4. Care coordination, internal reporting on quality and cost, evidence based medicine, and patient engagement
5. False
6. All ways to report are correct
7. True
8. Physician Self-Referral Law
9. SNF 3-Day Rule and waiving originating site requirements for telehealth services
10. All are key requirements for the conflict of interest policy.