Title: Deficit Reduction and False Claims Prevention Policy
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Policy# CC14

Purpose:

To ensure Affected Individuals of the Care Compass Entities understand expectations regarding the prevention of fraud, waste, and abuse pertaining to operations of the Care Compass Entities.

Definitions:

Affected Individual(s): All persons who are affected by Care Compass Entities' risk areas including Care Compass Entities' employees, officers, Directors, managers, contractors, agents, subcontractors, independent contractors, governing bodies, or third-parties, who or that, in acting on behalf of the Care Compass Entities: (i) delivers, furnishes, directs, orders, authorizes, or otherwise provides health or social care items and services under State, Federal, or Care Compass programs; and (ii) contributes to the Care Compass Entities' entitlement to payment under Federal health or social care programs, or from other payor sources.

Care Compass Entities: Organizations that are directly, or indirectly through one or more intermediaries, owned or controlled by, or are under common ownership or control of, Care Compass Network, including Care Compass Collaborative, Inc., and Care Compass Supporting IPA, LLC.

Claim: Any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that is presented to an officer, employee, or agent of the United States; or is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government provides or has provided any portion of the money or property requested or demanded; or will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

Knowing(ly): That a person, with respect to information: 1) has actual knowledge of the information; 2) acts in deliberate ignorance of the truth or falsity of the information; or 3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

Material: having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

Obligation: An established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment.

Participants: Any organization that has signed an agreement related to a funded program with the Care Compass Entities.

Report: Letter Attestations, invoices, and data submitted through the Secure File Transfer Program (SFTP) site or IT platform by Participants and vendors for payment.

Staff: Employees, contractors, agents, consultants, volunteers, and others who act on the Care Compass Entities' behalf.

Policy:

The Care Compass Entities are committed to ensuring regulatory compliance and the communication of expectations regarding the prevention of fraud, waste, and abuse pertaining to the operations of the Care Compass Entities.

I. Compliance Program. The Care Compass Entities are committed to conducting their operations in accordance with applicable laws, regulations, and policies. The Care Compass Entities have a comprehensive compliance program (Compliance Program) and policies and procedures to detect, prevent, and remediate fraud, waste, and abuse.

a. The Code of Conduct for Boards of Directors, Governance Committees, and Staff of the Care Compass Entities and the Code of Conduct for their Participants (collectively, the Codes of Conduct) lay out the substantive standards and expectations of the Compliance Program.
b. The Compliance Policies and Procedures specify the processes to carry out the Compliance Program. All Staff receive training on, and have access to, these policies and procedures.
c. The Compliance Program documents, including the Codes of Conduct and Compliance Policies and Procedures, are available in the Care Compass Entities shared file locations and Smartsheet dashboards.

II. Verification of Submissions for Payment. The Care Compass Entities are committed to ensuring that information submitted to the Care Compass Entities for payment is accurate.

a. Each Staff member must know or believe that the information contained in a report, or supporting documentation for a report, he or she verifies and submits to the Finance Department is correct.
b. Staff cannot, either deliberately or carelessly, ignore questionable information in a report, or supporting documentation for a report, that an Affected Individual, Participant, or vendor submits.
c. Ensuring that information is true and accurate includes making reasonably sure that essential facts are accurate and that no essential fact is omitted.

III. Deficit Reduction Act. The Deficit Reduction Act of 2005 (DRA) mandates notification about certain compliance laws for organizations that receive $5 million or more, annually, in Medicaid payments.

a. The DRA is intended to reduce fraud, waste, and abuse in federal and state health care programs through employee and contractor education about:
    i. Federal and state laws that prohibit false claims;
    ii. Civil and criminal penalties; and
    iii. Protections from retaliation for employees who report wrongdoing, misconduct, or violations of laws and regulations in good faith.

IV. Federal False Claims Act. The Federal False Claims Act (the "Act", 31 USC §§3729-3733) covers fraud involving any federally-funded contract or program, including Medicare or Medicaid, and establishes civil liability for any individual or entity, including Affected Individuals and Participants, that knowingly presents or causes to be presented a false or fraudulent claim to the United States government ("Government"). "Knowingly" includes not only actual knowledge, but also deliberate ignorance or reckless disregard for the truth or falsity of the information.

a. Specifically, the Act sets forth seven circumstances for which civil liability will be imposed for false claims. These seven circumstances are:
    i. knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
    ii. knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
    iii. conspires to commit a violation of subparagraph (i), (ii), (iv), (v), (vi), or (vii);
    iv. has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;
    v. is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
    vi. knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or
    vii. knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,
b. The Act applies to claims submitted under Medicare, Medicaid, other federal health care programs and other state health care programs funded, in whole or in part, by the federal government. Examples of false claims include, but are not limited to:
    i. Filing a claim for payment knowing that the services were not provided or were unnecessary;
    ii. Submitting a claim for payment knowing that excessive charges are being billed;
    iii. Submitting a claim for payment knowing that a higher billing code, which does not reflect the services provided, is used;
    iv. Filing a claim knowing that the claim is for duplicate services.
c. Civil monetary penalties may be imposed upon a person for making a false claim to the Government where the individual knows the information in the claim is false, or acts in deliberate ignorance of the truth or falsity of the information in the claim, or acts in reckless

disregard of the truth or falsity of the information in the claim. Civil monetary penalties are imposed even where there is no specific intent to defraud the Government.

d. In addition, pursuant to 42 U.S.C. §1320a-7k(d), if a person fails to report and return an identified overpayment within 60 days of identification, the overpayment is considered an "obligation" under §3729 and subject to the penalties provided for under the False Claims Act.
e. The civil penalty that can be imposed for a false claim under the Act is not less than $10,781 and not more than $21,563, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. §2461), **PLUS** three times the amount of damages which the Government sustained because of the false claim, **PLUS** the costs of a civil action to recover the penalties.[1]
f. A provider or contractor found in violation may also be excluded from participation in federal or state health care programs.
g. Enforcement of the Act is the responsibility of the United States Attorney General.
    i. Private individuals have the ability to bring a civil action for a violation of §3729 of the Act. These private actions are known as "Qui Tam" actions.
    ii. Qui Tam actions are brought by private individuals in the name of the Government.
    iii. A civil action under the Act may not be brought:
        1. More than six years after the date on which the violation of the Act is committed; or
        2. More than three years after the date when facts material to the right of action are known or reasonably should have been known by an official of the Government charged with responsibility to act in the circumstances but in no event more than 10 years after the date on which the violation is committed, whichever occurs last.

V. Federal Administrative Remedies for False Claims and Statements (31 U.S.C. §3801 et. seq.). Section 3801 imposes additional civil penalties for the filing of false claims or statements with the Government, which are conducted through an administrative process.

a. Claims are defined as any request, demand, or submission:
    i. made to the Government for property, services, or money (including money representing grants, loans, insurance, or benefits);
    ii. made to a recipient of property, services, or money from the Government or to a party to a contract with the Government:
        1. for property or services, if the United States:
            (a) provided such property or services;
            (b) provided any portion of the funds for the purchase of such property or services; or

[1] A Court may impose a lesser penalty of not less than two times the amount of damages sustained by the Government where the Court finds the following:

1. The person committing the violation furnished governmental officials responsible for investigating false claims with all information known to the person about the violation within thirty (30) days after the date on which the person first obtained the information;
2. The person fully cooperated with any governmental investigation of the violation; and
3. At the time the person furnished the Government with the information about the violation, no criminal prosecution, civil action, or administrative action had been commenced with respect to the violation and the person did not have actual knowledge of the existence of an investigation into the violation.

(c) will reimburse such recipient or party for the purchase of such property or services; or

2. for the payment of money (including money representing grants, loans, insurance, or benefits), if the United States:
   (a) provided any portion of the money requested or demanded; or
   (b) will reimburse such recipient or party for any portion of the money paid on such request or demand; or
3. which has the effect of decreasing an obligation to pay or account for property, services, or money, except that such term does not include any claim made in any return of tax imposed by the Internal Revenue Code of 1986.

b. Civil monetary penalties under 31 U.S.C. §3801 et. seq. will be imposed against:
   i. Any person (individual or entity) who makes, presents, or submits, or causes to be made, presented, or submitted, a claim that the person knows or has reason to know:
      1. is false, fictitious, or fraudulent;
      2. includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent;
      3. includes or is supported by any written statement that:
         (a) omits a material fact;
         (b) is false, fictitious, or fraudulent as a result of such omission; and
         (c) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material facts; or
      4. Is for payment for the provision of property or services which the person has not provided as claimed; or
   ii. Any person who makes, presents, or submits, or causes to be made, presented, or submitted, a written statement that:
      1. The person knows or has reason to know:
         (a) asserts a material fact which is false, fictitious, or fraudulent; or
         (b) is false, fictitious, or fraudulent as a result of such omission;
         (c) in the case of a statement described in clause (b) of subparagraph (1) in which the person making, presenting, or submitting such statement has a duty to include such material fact; and
         (d) contains or is accompanied by an express certification or affirmation of the truthfulness or accuracy of the contents of the statement.

c. Civil monetary penalties under 31 U.S.C. §3801 et. seq. are not more than $5,000 for each false claim or statement (31 U.S.C. §3802). Also, in lieu of damages sustained by the federal government, an assessment of not more than twice the amount of such claim(s) may be imposed. An individual or entity against whom civil monetary penalties are sought under 31 U.S.C. §3801 et. seq. is entitled to notice, an opportunity for a hearing, and judicial review (31 U.S.C §§3803-3812).
d. Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, rather than when it is paid. Also, unlike the False Claims Act, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency, not by prosecution in the federal court system.

VI. Additional Federal Civil and Criminal Penalties and Sanctions for False Claims.

a. 42 U.S.C. §1320a-7a (Civil).

i. The federal government may, pursuant to 42 U.S.C. §1320a-7a, impose civil monetary penalties ("CMP") for improperly filed claims. Such claims include those knowingly presented that were:

1) for items or services that a person knew or should have known were not provided as claimed, including up coding;
2) false or fraudulent;
3) for services that a person knew or should have known were by unqualified providers;
4) provided by providers excluded from federal health care program reimbursement;
5) for services or items that a person knew or should have known were unnecessary;
6) in violation of assignment, agreement on limited charge, or provider agreement.

ii. §1320a-7a also provides for penalties for the following additional acts, including:

1) being excluded from federal health care program reimbursement and owning or being an officer of an entity submitting such claims;
2) providing remuneration to influence beneficiaries;
3) contracting with an excluded individual or entity for which reimbursement is made;
4) participating in kickback or improper or rebate referral remuneration;
5) knowingly making or using a material false record or statement for a claim;
6) failing to timely permit access to OIG for audit;
7) knowingly making or causing to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under a Federal health care program;
8) knowing of and failing to report and return overpayment.

iii. The CMP for the above violations may be assessed in addition to any other penalty prescribed by law. The penalties may be up to $10,000 for each item or service with some exceptions[2]. In addition, a violator shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim.[3]

iv. The Secretary of Health and Human Services ("Secretary") may also make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1320a–7b (f)(1)) and to

[2] $15,000 for each person provided false or misleading hospital discharge information is give; $10,000 per day for excluded individual ownership or officer/manager participation in billing entity; $50,000 for participating in kickback or improper or rebate referral remuneration; $50,000 for each material false record or statement relating to claim; $15,000 per day for denial of audit access; and $50,000 for each false statement, omission, or misrepresentation of a material fact in any application, etc.

[3] Where violation is bribe, kickback or other improper remuneration, it is 3 times the remuneration. Where violation is for false statement, omission, or misrepresentation of a material fact in any application, it is 3 times the amounts claimed under the application contract.

direct the appropriate State agency to exclude the person from participation in any State health care program.

v. In addition to civil monetary penalties, the federal government may, pursuant to 42 U.S.C. §1320a-7, exclude an individual or entity from participation in federal and state health care programs (including Medicare and Medicaid) for certain false claims or actions. Generally, exclusion is mandatory in cases where the individual is convicted of a felony relating to health care fraud, otherwise, exclusion is permissive, that is, subject to the discretion of the Government.

b. 42 U.S.C. §1320a-7k(d)(2).

i. Pursuant to 42 U.S.C. §1320a-7k(d)(2) (enacted as §6402 of the Patient Protection and Affordable Care Act), providers are obligated to report, explain and repay overpayments within 60 calendar days of identification. Those that fail to properly disclose, explain, and repay the overpayment in a timely manner may be subject to liability under the New York and Federal False Claims Act.

c. 42 U.S.C. §1320a-7b (Criminal).

i. Pursuant to 42 U.S.C. §1320a-7b, criminal sanctions may be imposed against an individual or entity for making or causing to be made false statements or representations. Specifically, criminal sanctions will be imposed against an individual or entity who:

1. Knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a federal health care program;
2. At any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefits or payments;
3. Having knowledge of the occurrence of any event affecting (i) his/her initial or continued right to any such benefit, or (ii) the initial or continued right to any such benefit or payment of any other individual in whose behalf he/she has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized;
4. Having made an application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person;
5. Knowingly and willfully, for a fee, counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for assistance under Medicaid if disposing of the assets results in the imposition of a period of ineligibility for such assistance.

VII. New York State Prohibition Against False Claims.

a. New York False Claims Act; State Finance Law §§187-194 (Civil).

i. Bars reliance on false or fraudulent statements to obtain payment of state funds, including Medicaid. For purposes of New York State law, a "statement" includes

any claim, ratification or report of data which serves as the basis for a claim, or financial or other information submitted as a basis to seek payment of Medicaid funds.

ii. A violation will occur if a person or organization knows that the claim or statements supporting it are false or fraudulent.

iii. The penalty or fine for a false claim under New York State Law may include:
    1. Civil damages[4] in three times the amount of any claim or false figure submitted for reimbursement;
    2. An amount equal to $6,000 up to $12,000 plus three times the amount of all damages; and
    3. Any other remedies available under law, including criminal liability.

iv. Prohibited acts under State Finance Law §189 include:
    1. knowingly presenting, or causing to be presented a false or fraudulent claim for payment or approval;
    2. knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
    3. conspiring to commit a violation of the Act;
    4. having possession, custody, or control of property or money used, or to be used, by the state or a local government and knowingly delivering, or causing to be delivered, less than all of that money or property;
    5. being authorized to make or deliver a document certifying receipt of property used, or to be used, by the state or a local government and, intending to defraud the state or a local government, making or delivering the receipt without completely knowing that the information on the receipt is true;
    6. knowingly buying, or receiving as a pledge of an obligation or debt, public property from an officer or employee of the state or a local government knowing that the officer or employee violates a provision of law when selling or pledging such property;
    7. knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state or a local government; or
    8. knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the state or a local government, or conspiring to do the same.

v. The false claim filer may have to pay the Government's costs and legal fees expended to recover the damages.

vi. The New York False Claim Act also allows private individuals to file civil lawsuits (Qui Tam) in state court, just as if they were state or local government parties.

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[4] The amount may be dropped to 2 times the damages if the court finds that the violator self-disclosed fully within 30 days of having knowledge, fully cooperated with officials and if the self-disclosure was before criminal, civil or administrative prosecution and the violator had no knowledge of investigation.

b. Social Services Law, Section 366-b (Criminal).
    i. Section 366-b of the Social Services Law makes it a Class A misdemeanor for any person who, with intent to defraud, does any of the following:
        1. presents for allowance or payment any false or fraudulent claim for furnishing services;
        2. knowingly submits false information for the purpose of obtaining greater compensation than that to which he/she is legally entitled for furnishing services; or
        3. knowingly submits false information for the purpose of obtaining authorization for furnishing services under the Medicaid program.
c. Article 177 of the Penal Law (Criminal).
    i. Article 177 of the Penal Law establishes the crime of health care fraud.
        1. The crime of health care fraud in the fifth degree is a Class A misdemeanor and a person is guilty of this crime when, with intent to defraud a health plan, including the State Medicaid program, he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan for a health care item or service and, as a result of such information or omission, he or she or another person receives payment in an amount that he, she, or such other person is not entitled to under the circumstances.
        2. The crime of health care fraud in the fourth degree is a Class E felony and a person is guilty of this crime when the person commits the crime of health care fraud in the fifth degree on one or more occasions and the payment or portion of payment wrongfully received from a single health plan, including Medicaid, in a period of not more than one year, exceeds $3,000 in the aggregate.
        3. The crime of health care fraud in the third degree is a Class D felony and is committed where the wrongful payments exceed $10,000 in the aggregate in a one-year period.
        4. The crime of health care fraud in the second degree is a Class C felony and is committed where the wrongful payments exceed $50,000 in the aggregate in a one-year period.
        5. The crime of health care fraud in the first degree is a Class B felony and is committed where the wrongful payments exceed more than $1,000,000 in the aggregate in a one-year period.
    ii. Article 177 of the Penal Law provides for an affirmative defense for individuals serving as a clerk, bookkeeper, or other employee of a health care provider who, without personal benefit, was merely executing the orders of his or her employer or a superior employee generally authorized to direct his or her activities. The affirmative defense is not available to any employee charged with the active management and control, in an executive capacity, of the affairs of the corporation.
d. Penal Law Article 175 - False Written Statements (Criminal).
    i. Four crimes are set forth relating to filing false information or claims and have been applied in Medicaid fraud cases:

1. §175.05, falsifying business records, involves entering false information, omitting material information, or altering an entity's business records with the intent to defraud. (Class A misdemeanor)
2. §175.10, falsifying business records in the first degree includes the elements of the §175.05 offense and includes the intent to commit another crime or conceal its commission. (Class E felony)
3. §175.30, offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. (Class A misdemeanor)
4. §175.35, offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. (Class E felony)

e. 18 NYCRR Section 515.2 (Administrative). It is an unacceptable practice under the Medicaid program for an individual or entity to submit false claims or false statements to Medicaid.
   i. False claims include:
      1. Submitting, or causing to be submitted, a claim or claims for:
         (a) unfurnished care, services or supplies;
         (b) an amount in excess of established rates or fees;
         (c) medical care, services or supplies provided at a frequency or in amount not medically necessary; or
         (d) amount substantially in excess of the customary charges or costs to the general public; or
      2. Inducing, or seeking to induce, any person to submit a false claim.
   ii. False statements are:
      1. Making, or causing to be made, any false, fictitious, or fraudulent statement or misrepresentation of material fact in claiming a payment, or for use in determining the right to payment; or
      2. Inducing or seeking to induce the making of any false, fictitious, or fraudulent statement or misrepresentation of a material fact.
   iii. Individuals who have engaged in unacceptable practices under the Medicaid program are subject to one or more of the following sanctions:
      1. Exclusion from the program for a reasonable time;
      2. Censure;
      3. Conditional or limited participation, such as requiring pre-audit or prior authorization of claims for all medical care, services or supplies, prior authorization of specific medical care, services or supplies, or other similar conditions or limitations;
      4. The Department of Health may require the repayment of overpayments determined to have been made as a result of the unacceptable practice.

VIII. Whistleblower Provisions and Protections. The Care Compass Entities support and promote activities to identify and report suspected fraudulent activity and unethical behavior while maintaining a work environment that encourages Affected Individuals and Participants to take an active part in the investigative process without fear of retaliation or negative impact in accordance

with its ENT_CC4 Whistleblower Policy. Both federal and New York State law protect whistleblowers who act in good faith from retaliation or harassment of any kind for reporting an action, policy, or practice that constitutes fraud, or for taking other actions to further the purposes of the False Claims Act.

IX. Reporting Instances of Non-Compliance.

a. Any Staff, Affected Individual, or Participant who has a good faith belief, based on objective information, that a false report, or supporting documentation for a report, has been submitted, must report it following the ENT_CC5-1 Reporting Non-Compliance Procedure.
b. Staff, Affected Individuals, and Participants have a responsibility, and are required to report promptly, any activity in a Care Compass Entities project, program, or operations that appears to violate applicable laws, rules, regulations, or the Codes of Conduct directly to the Director of Compliance, or through the online Compliance Hotline at https://bit.ly/CareCompass-Compliance.

X. Failure to Report.

a. Proven failure to report misconduct may result in disciplinary action, up to and including termination from employment, removal from an appointed position, or removal from the Care Compass Entities Networks, against the Staff, Affected Individual, or Participant who failed to report the misconduct.
b. In addition, managers, supervisors, Affected Individuals, and Participants may be sanctioned for failing to detect non-compliance with applicable laws or policies and procedures where reasonable diligence on the part of the manager or supervisor or Participant would have led to the discovery of a problem or violation.

XI. Non-Retaliation.

a. No retaliatory action will be taken or allowed against any Staff, Affected Individual, or Participant who, in good faith, reports actual or suspected instances of non-compliance.
b. Appropriate disciplinary action, up to and including termination from employment, removal from an appointed position, or removal from the Care Compass Entities Networks, shall be taken against any Staff, Affected Individual, or Participant found to have retaliated against any individual or organization who reported in good faith.

CCN Board Approval History: 6/12/2018, 2/12/2019, 12/10/2019, 11/10/2020, 11/9/2021, 11/8/2022, 8/08/2023, 8/13/2024, 6/10/2025

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Policy Revisions:

Date	Revision Log	Updated By
5/18/2018	Original creation	Andrea Rotella
1/18/2019	Updated definition of "staff" and other changes by the Compliance and Audit Committee	Andrea Rotella
11/15/2019	Updated with changes by the Compliance and Audit Committee	Andrea Rotella
10/16/2020	Removal of references to DSRIP	Andrea Rotella
3/12/2021	Updated with changes to the Compliance Hotline	Cathy Petrak
9/1/2021	Removal of references to PPS and SharePoint	Cathy Petrak
8/29/2022	Added Partner definition and updated Partner Organization to Partner throughout	Cathy Petrak
7/14/2023	Updated Partner to Participant and online Compliance Hotline link throughout	Cathy Petrak
5/12/2025	Updated to enterprise-wide; included BS&K edits for DRA requirements for covered entities	A.Rotella & BS&K

This Policy shall be reviewed periodically, but not less than once every 12 months, and updated consistent with the requirements established by the Board of Directors, Care Compass Network's Leadership Team, Federal and State law(s) and regulations, and applicable accrediting and review organizations.