WellSense HEALTH PLAN

Medicare and Medicaid Compliance Guide

Medicare First-tier, Downstream and Related Entities (FDRs) and Other Medicaid Subcontractors

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Introduction

Medicare Advantage (MA) plans, such as those offered by WellSense Health Plan (WellSense or the Plan), contract with the Centers for Medicare & Medicaid Services (CMS) to provide services under the Medicare Parts C and D programs. To help fulfill our obligations to CMS, WellSense contracts with individuals/entities to provide or arrange for certain administrative and/or health care services. These contractual arrangements may cause an individual/entity to be identified as a **First-tier, Downstream and Related Entity** (FDR) if such delegated services meet certain CMS standards.

Additionally, Medicaid managed care plans, such as those offered by WellSense, contract with state Medicaid agencies including the Massachusetts Executive Office of Health and Human Services (EOHHS) and the New Hampshire Department of Health and Human Services (NH DHHS) to provide services under the Medicaid program. To help fulfill our obligations to these agencies, WellSense contracts with individuals and/or entities to provide or arrange for certain administrative and/or health care services. These contractual arrangements may cause an individual/entity to be identified as a **Material Subcontractor** in Massachusetts and a **Contractor** in New Hampshire if such delegated services meet certain CMS standards.

For purposes of this Compliance Guide and unless otherwise specified, WellSense collectively refers to FDRs, Material Subcontractors and Subcontractors as **Suppliers.**

WellSense is committed to compliance with all applicable laws, regulations and contract requirements set forth by CMS, EOHHS and NH DHHS and holds itself to the highest compliance and ethical standards. We expect the same of our Suppliers.

WellSense is ultimately responsible for fulfilling the terms and conditions of our contracts with CMS, EOHHS and NH DHHS, meeting the Medicare and Medicaid program requirements and delivering service to our members. Although services may be delegated to a Supplier, WellSense is accountable for the failure of any of its Suppliers to comply with applicable Medicare and Medicaid program requirements.

The purpose of this Medicare and Medicaid Compliance Guide (Compliance Guide) is to assist our Suppliers in fully understanding and meeting their compliance obligations under WellSense's Medicare and Medicaid Compliance Programs. Please use it as a "quick reference" guide to understanding our compliance program expectations and ensuring you have internal processes to support your compliance program.

In the event of any inconsistency between this Compliance Guide and the terms of your agreement with WellSense, the terms of your agreement shall prevail.

Please refer to the **Resources** section of this Compliance Guide for more information on compliance program requirements.

Definitions

Accountable Care Organizations (ACOs): Certain entities, contracted with Massachusetts EOHHS as accountable care organizations that enter into population-based payment models with payers, such as WellSense, wherein the entities are held financially accountable for the cost and quality of care for an attributed Member population. Entities that enter into contracts with Massachusetts EOHHS pursuant to the RFR are ACOs.

Centers for Medicare & Medicaid Services (CMS): The federal agency that provides health coverage to more than 160 million people through Medicare, Medicaid, the Children's Health Insurance Program and the Health Insurance Marketplace

First-tier Entity: Any party that enters into a written arrangement with WellSense, acceptable to CMS, to provide administrative services or health care services to a Medicare-eligible individual under the MA program or Part D program.

Downstream Entity: Any party that enters into a written arrangement with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between WellSense and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Massachusetts Executive Office of Health and Human Services (EOHHS): The state agency that is responsible for the administration of the MassHealth Program.

Material Subcontractor (ACO/MCO/SCO): Any entity from which WellSense

procures, re-procures, or proposes to subcontract with, for the provision of all, or part, of its Administrative Services for any program area or function that relates to the delivery or payment of ACO, MCO and SCO Covered Services including, but not limited to, behavioral health, claims processing, Care Management, Utilization Management or pharmacy benefits, including specialty pharmacy providers.

New Hampshire Department of Health and Human Services (NH DHHS): The largest agency in New Hampshire state government responsible for the health, safety and well-being of the citizens of New Hampshire. DHHS provides services for individuals, children, families and seniors, and administers programs and services such as mental health, developmental disability, substance misuse, and public health.

Related Entity: Any entity that is related to WellSense by common ownership or control and

1. performs some of WellSense's management functions under contract or delegation;
2. furnishes services to Medicare enrollees under an oral or written agreement; or
3. leases real property or sells materials to WellSense at a cost of more than $2,500 during a contract period.

Senior Care Options Program (SCO): A program implemented by Massachusetts EOHHS in collaboration with CMS for the purpose of delivering and coordinating all Medicare- and Medicaid-covered benefits for eligible Massachusetts seniors managed by a SCO using a Geriatric Model of Care.

Subcontract: Any separate contract or written agreement between WellSense and an individual or entity, subject to approval by NH DHHS, to perform all or a portion of WellSense duties and obligations related to its Medicaid care management contract.

Subcontractor: A person or entity delegated by WellSense to perform an administrative function or service on behalf of the Contractor that directly or indirectly relates to the performance of all or a portion of the duties or obligations under this Agreement. A Subcontractor does not include a Participating Provider.

Supplier: A term used to describe a First-tier, Downstream and Related Entity, Material Subcontractor or Subcontractor.

How WellSense Identifies Suppliers as FDRs

WellSense evaluates the types of functions delegated to the third party and makes a determination, in accordance with CMS standards, whether the performance of those functions cause that individual or entity to be identified as an FDR. The following are a few examples that, if delegated to the third party, presumptively make that third party an FDR:

- Sales and marketing
- Quality improvement
- Claims administration, processing and coverage adjudication
- Licensing and credentialing
- Hotline operations
- Bid preparation
- Entities that generate claims data
- Utilization management
- Enrollment, disenrollment and membership functions
- Appeals and grievances
- Pharmacy benefits management
- Customer Service
- Outbound sales verification
- Health care services

FDRs delegated to perform a core function of WellSense must follow all CMS Medicare program requirements and regulations, just as WellSense is required to do when providing a core function directly. As such, WellSense has developed and implemented clearly defined processes to evaluate and categorize which third parties are FDRs. In addition to the examples listed above, WellSense also utilizes the following factors to determine whether a third party is an FDR:

- The function to be performed by the third party
- Whether the function is something the sponsor must do or provide under its contract with CMS, applicable federal regulations or CMS guidance
- To what extent the function directly impacts enrollees
- To what extent the third party interacts with enrollees, either orally or in writing
- Whether the third party has access to beneficiary information or protected health information (PHI)
- Whether the third party has decision-making authority (e.g., enrollment third party deciding time frames) or whether the entity strictly takes direction from the sponsor
- The extent to which the function places the delegated entity in a position to commit health care fraud, waste or abuse (FWA).
- The risk that the third party could harm enrollees or otherwise violate Medicare program requirements or commit FWA

How WellSense Identifies Suppliers as Material Subcontractors or Subcontractors

WellSense may delegate administrative or health care service functions to a third party. This relationship may cause the individual or entity to be identified by WellSense as a Material Subcontractor if the activity is a core function of WellSense's ACO, MCO, or SCO programs under its contracts with EOHHS, or to be identified as a Subcontractor if the activity is a core function of WellSense's Medicaid program under its contract with NH DHHS.

The following are a few examples that, if delegated to the third party, presumptively make that third party a Material Subcontractor or Subcontractor:

- Enrollment and eligibility functions
- Coordination of covered services
- Performing required assessments
- Utilization management functions
- Provider contracting and credentialing functions
- Claims payment functions
- Quality or Care Management functions

In addition to the examples listed above, WellSense also utilizes the following factors to determine whether a third party is a Material Subcontractor or Subcontractor:

- The function to be performed by the third party
- Whether the function is something the sponsor must do or provide under its EOHHS or NH DHHS contract, other applicable state or federal regulations or EOHHS or NH DHHS guidance
- To what extent the function directly impacts enrollees
- To what extent the third party interacts with enrollees, either orally or in writing
- Whether the third party has access to beneficiary information or PHI
- Whether the third party has decision-making authority (e.g., enrollment third party deciding time frames) or whether the entity strictly takes direction from the sponsor
- The extent to which the function places the delegated entity in a position to commit health care FWA
- The risk that the third party could harm enrollees or otherwise violate Medicaid program requirements or commit FWA

Compliance with State and Federal Requirements

Suppliers must operate in accordance with all applicable state and federal laws, regulations, Medicare and Medicaid program requirements, CMS, EOHHS and NH DHHS guidance and CMS instructions as applicable, including:

Anti-Kickback Statute (42 USC § 1320a-7b(b)) prohibits anyone from knowingly and willfully receiving or paying anything of value to influence the referral of federal health care program business, including Medicare and Medicaid. Kickbacks can take many forms, such as cash payments, entertainment, credits, gifts, free goods or services, the forgiveness of debt or the sale or purchase of items at a price inconsistent with fair market value. Kickbacks may also include the routine waiver of copayments and/or co-insurance. Penalties for Anti-Kickback violations include fines, imprisonment, civil money penalties and exclusion from participation in federal health care programs.

Beneficiary Inducement Statute (42 USC § 1128A(a)(5)) makes it illegal to offer remuneration that a person knows, or should know, is likely to influence a beneficiary to select a particular provider, practitioner or supplier, including a retail, mail order or specialty pharmacy.

Federal and State False Claims Acts (31 USC §§ 3729-3733) prohibits any person from engaging in any of the following activities:

- knowingly submitting a false or fraudulent claim for payment to the United States government
- knowingly making a false record or statement to get a false or fraudulent claim paid or approved by the government
- conspiring to defraud the government by getting a false or fraudulent claim paid or approved by the government
- knowingly making a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the government

Federal Criminal False Claims Statutes (18 USC §§ 287, 1001) make it a criminal offense for anyone to make a claim to the United States government knowing that it is false, fictitious or fraudulent.

Federal Regulations including:

- 42 CFR §422: Medicare Advantage (Part C) program. This regulation implements the Medicare Advantage program under the Social Security Act.
- 42 CFR §423: Prescription drug (Part D) program. This regulation implements the prescription drug program under the Social Security Act.
- 42 CFR §438: Managed Care Program. This regulation implements the state and federal managed care program under the Social Security Act.

Fraud Enforcement and Recovery Act (FERA) made significant changes to the FCA. FERA makes it clear that the FCA imposes liability for the knowing retention of a Medicare or Medicaid overpayment. Consequently, a health plan or provider may violate the FCA if it conceals, improperly avoids, or decreases an "obligation" to pay or refund money to the government.

Health Insurance Portability and Accountability Act (HIPAA) was developed as part of a congressional effort to reform health care. HIPAA addresses many purposes, such as the transference of health insurance, the reduction of fraud and abuse and the improvement of access to long-term care services. The regulations regarding privacy and administrative simplification of health insurance are the areas of HIPAA that have the greatest impact on Medicare & Medicaid plans.

Physician Self-Referral (Stark) Law (42 USC §1395nn) prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or an immediate family member) has a financial relationship, unless an exception applies. Stark Law further prohibits the designated health services entity from submitting claims to Medicare for services resulting from a prohibited referral. Penalties for Stark Law violations include overpayment and/or refund obligations, FCA liability and civil monetary penalties. Stark Law is a "strict liability" statute and does not require proof of intent.

Title XVIII of the Social Security Act established the Medicare program and which guarantees access to health insurance for all Americans aged 65 and older, younger persons with specific disabilities and individuals with end-stage renal disease.

Title XIX of the Social Security Act established the Medicaid program, which provides funding for medical and health-related services for persons with limited income

Compliance Program Requirements for all Suppliers

As a state and federal contractor, WellSense must comply with applicable CMS, EOHHS and NH DHHS compliance program requirements. As a Supplier, your organization and all of your downstream entities (if applicable) must comply with the same compliance program requirements. Suppliers are also responsible for ensuring that their downstream entities comply with applicable laws and regulations, including the requirements in this Compliance Guide, which summarizes your compliance program responsibilities and may be shared with downstream entities.

The seven (7) elements of an effective compliance program include

Element	Description
Element 1: Written Policies and Procedures and Standards of Conduct	Describes the principles and values by which WellSense operates. These include WellSense organizational policies, a *Code of Conduct* for our employees and the *Medicare & Medicaid Compliance Guide For Medicare First-tier, Downstream and Related Entities (FDRs) and Other Medicaid Subcontractors.*
Element 2: Compliance Leadership and Oversight	Designation of an individual (Compliance Officer) vested with the day-to-day operations of the WellSense Compliance Program and a committee that oversees the overall compliance program.
Element 3: Effective Training and Education	Provides for comprehensive training and education on WellSense's compliance activities including general compliance, HIPAA, FWA and other applicable rules and regulations.
Element 4: Effective Lines of Communication	Describes pathways for WellSense Compliance staff to communicate with the workforce, and outlines methods to report potential non-compliance and/or instances of FWA.
Element 5: Well-Publicized Disciplinary Standards	Describes disciplinary policies and procedures, which reflect clear and specific disciplinary standards, and encourages good-faith participation in the WellSense Compliance Program without fear of retaliation.
Element 6: Effective System for Routine Monitoring and Identification of Compliance Risks	Comprehensive processes for identifying, analyzing, and responding to potential risks, including monitoring and auditing of operational and regulatory requirements.
Element 7: Prompt Response to Compliance Issues	Describes process for investigation and remediation of compliance issues.

You can find these compliance program requirements in:

- CMS Compliance Program Policy and Guidance
- US DHHS OIG Compliance Guidance
- 42 CFR §§422.503(b)(4)(vi), 423.504(b)(4)(vi), 438.608(a)(1)

Written Policies, Procedures and Standards of Conduct

Each Supplier must establish internal compliance policies and procedures and/or standards of conduct that communicate the organization's compliance expectations and CMS, EOHHS and NH DHHS compliance program requirements. You may use and provide a copy of WellSense's Code of Conduct if you do not have one of your own. These materials must be provided:

- within 90 days of initial hire or the effective date of contracting
- whenever there are updates to the documentation
- annually thereafter

Suppliers can determine the most effective method of distributing the policies and procedures or standards of conduct, including providing a hardcopy or electronic copy at the time of hire/contract or posing a copy on the Supplier's intranet site. A Supplier must maintain documentation that demonstrates the information was distributed. You can find these standards of conduct requirements in:

- CMS Compliance Program Policy and Guidance
- US DHHS OIG Compliance Guidance
- 42 CFR §§422.503(b)(4)(vi)(A), 423.504(b)(4)(vi)(A), 438.608(a)(1)

General Compliance and Fraud, Waste and Abuse (FWA) Training

Suppliers must develop their own training specific to its organizational needs to train staff on relevant general compliance topics and prevention of FWA.

Suppliers are not exempt from general compliance training requirements but may be deemed to have met the FWA training and education requirements through enrollment in Parts A or B of the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier.

General compliance and FWA training must be completed:

- within 90 days of initial hire or the effective date of contracting
- whenever there are updates to the documentation
- annually thereafter

Suppliers should keep training logs or other evidence of completion, which should include, at a minimum, the employee or contractor name, date(s) of completion, and passing score if captured.

You can find these training requirements in:

- CMS Compliance Program Policy and Guidance
- US DHHS OIG Compliance Guidance
- 42 CFR §§422.503(b)(4)(vi)(C), 423.504(b)(4)(vi)(C), 438.608(a)(1)

Exclusion Screening

Federal law prohibits the payment by Medicare, Medicaid or any other federal health care program for an item or service furnished by a person or entity excluded from participation in these federal programs. WellSense, its Suppliers and providers are prohibited from contracting or doing business with any person or entity excluded from participation in these state or federal programs.

Suppliers must perform exclusion screening checks to confirm individuals or entities performing administrative or health care services for WellSense are not excluded from participation in federally funded health care programs according to the Office of Inspector General's List of Excluded Individuals and Entities (OIG LEIE), the Government Services Administration's System for Award Management (SAM) and, if applicable, the Office of Foreign Assets Controls (OFAC).

This includes employees, temporary employees, volunteers, consultants, governing body members and downstream entities. These screenings must be completed:

- prior to the initial date of hire and/or the effective date of contracting
- monthly thereafter

As part of WellSense's compliance program, WellSense requires its Suppliers to screen their employees and downstream entities. If any employees or downstream entities are found on any of the aforementioned exclusion lists, you must immediately remove the individual from work related directly or indirectly to WellSense and notify WellSense of your findings.

Suppliers must maintain evidence of their exclusion screening queries such as logs or other records for a minimum of 10 years.

You can find these exclusion screening requirements in:

- CMS Compliance Program Policy and Guidance
- US DHHS OIG Compliance Guidance
- OIG: https://exclusions.oig.hhs.gov/
- SAM: https://www.sam.gov/SAM/
- OFAC: Home | Office of Foreign Assets Control (treasury.gov)
- 42 CFR §§422.503(b)(4)(vi)(F), 423.504(b)(4)(vi)(F), 438.608(a)(1)

Questions on WellSense's exclusion screening processes may be directed to Exclusion.Screening@wellsense.org.

Reporting FWA and Compliance Issues to WellSense

As a Supplier, your organization must have effective lines of communication that foster compliance and the ability for employees and other parties to report suspected or detected non-compliance and FWA concerns. It's the duty of every person who has knowledge of a compliance issue or potential FWA concern to report such issues promptly. This reporting obligation applies even if the individual with the information is not able to mitigate or resolve the issue.

If a Supplier identifies areas of non-compliance (e.g., failure to conduct monthly exclusion screening), it must report the issue to WellSense and take prompt action to fix the issue and prevent it from happening again. Such reports must be provided to WellSense within 72 hours of discovery unless otherwise defined in your Agreement.

WellSense actions in response to a Supplier's non-compliance will depend on the severity of the compliance issue. WellSense maintains oversight policies outlining steps that WellSense would take if a Supplier fails to meet compliance program or WellSense

requirements, which may include developing a corrective action plan, retraining or termination of your contract with WellSense.

There are a number of ways to report suspected or detected non-compliance or potential FWA. WellSense has established a confidential compliance hotline for WellSense employees, providers, members, Suppliers, and other interested persons to report any violations or suspected violations of law and/or WellSense's compliance program.

Reports can be made by contacting the WellSense Compliance Hotline at **888-411-4959.** This toll-free hotline is accessible 24 hours a day, 365 days a year. All callers to the Compliance Hotline can report issues anonymously, and all reports will be referred to WellSense's Compliance department and investigated. You can also submit reports via email to compliance@wellsense.org. Reports of potential FWA issues may also be reported directly to our Special Investigations Unit (SIU) by emailing fraudandabuse@wellsense.org.

Suppliers must adopt and enforce a zero-tolerance policy for retaliation or intimidation against anyone who reports suspected misconduct in good faith.

Michael Comerford is WellSense's dedicated Medicare and Medicaid Compliance Officer. Questions or concerns for Michael or WellSense's Compliance Department can be directed to Compliance@wellsense.org.

You can find these reporting requirements in:

- CMS Compliance Program Policy and Guidance
- US DHHS OIG Compliance Guidance
- 42 CFR §§422.503(b)(4)(vi)(D), 423.504(b)(4)(vi)(D), 438.608(a)(1)

Record Retention and Record Availability

Suppliers must maintain evidence of compliance with all compliance program requirements for no less than 10 years. Suppliers must agree to audits and inspections by CMS, WellSense and/or its designees, and must cooperate, assist and provide information as requested. Documentation and records needed to meet Medicare, Medicaid or compliance program requirements must be maintained for no less than 10

years, including, but not limited to, attendance records, training certificates, and any other documents that demonstrate compliance with program requirements.

You can find these record retention requirements in:

- CMS Compliance Program Policy and Guidance
- US DHHS OIG Compliance Guidance
- 42 CFR §§422.503(b)(4)(vi)(F), 423.504(b)(4)(vi)(F), 438.608(a)(1)

Monitoring and Auditing of Suppliers

CMS, EOHHS, and NH DHHS require WellSense to develop a process to monitor and audit its Suppliers, promote compliance with all applicable laws and regulations, and ensure our Suppliers are monitoring their downstream entities for adherence with all applicable laws and regulations pertaining to Medicare and Medicaid program requirements.

WellSense regularly conducts monitoring and auditing activities of Suppliers to ensure compliance with Medicare and Medicaid program requirements. Suppliers subcontracting with other individuals or entities to provide administrative or health services are responsible for ensuring that any downstream entities comply with all applicable Medicare and Medicaid program requirements. This includes ensuring contractual agreements contain all CMS, EOHHS and NH DHHS required provisions, that each downstream entity complies with the Medicare and Medicaid compliance program requirements described in this Compliance Guide and that each downstream entity complies with any applicable Medicare and Medicaid operational requirements.

WellSense will audit a sample of its Suppliers annually, and Suppliers are required to cooperate fully and participate in WellSense-initiated monitoring and/or auditing activities. If a Supplier performs its own audits, WellSense may request a copy of the audit results as part of our oversight program.

Suppliers are also required to cooperate fully and participate in auditing activities conducted by federal, state, and local government agencies, including ensuring adherence to any audit timeline.

Suppliers must apply appropriate compliance program requirements to their downstream entities and provide sufficient oversight of their downstream entities, including auditing and monitoring to test and ensure each downstream entity is

compliant with applicable Medicare and Medicaid program requirements (including Medicare compliance program requirements). Suppliers must retain evidence of any oversight activities, ensure a root-cause analysis is conducted for any deficiencies, and implement corrective action as necessary to prevent the recurrence of noncompliance.

You can find these monitoring and auditing requirements in:

- CMS Compliance Program Policy and Guidance
- US DHHS OIG Compliance Guidance
- 42 C.F.R. §§422.503(b)(4)(vi)(F), 422.503(b)(4)(vi)(G), 423.504(b)(4)(vi)(F), 423.503(b)(4)(vi)(G)

Use of Offshore Operations

Because of the unique risks associated with using contractors operating outside the United States or one of its territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico and the Virgin Islands), we are required to take measures to ensure offshore contractors protect members' PHI. WellSense regulators are specifically concerned with entities that receive, process, transfer, handle, store or access members' PHI. Suppliers that work with offshore subcontractors to perform Medicare or Medicaid-related work that uses beneficiary PHI are required to provide WellSense with specific offshore subcontractor information and complete an attestation regarding the protection of beneficiary PHI.

Each Supplier is required to notify WellSense and obtain WellSense's consent prior to engaging with any potential offshore contractor if it has facilities or employees located outside of the United States and its territories for any work required under your contract with WellSense.

If WellSense consents to any offshore arrangement, the Supplier will be required to submit an attestation for any Medicare-related work required under the Supplier's contract with WellSense. The required information within the attestation must include, in part:

- the offshore subcontractor's name and functions
- a description of the PHI provided to the offshore subcontractor
- a description of safeguards adopted within the offshore subcontracting arrangement to protect beneficiary information

- the offshore subcontractor audit requirements

Annual Attestation

On an annual basis, an authorized representative from each Supplier is required to attest to compliance with the compliance program requirements described in this Compliance Guide. Depending on each Supplier's delegation arrangement, attestations may be specific to Medicare program requirements, Medicaid program requirements, or a combination of both, and all responses may be subject to audit.

Useful Resources

Compliance Chapters from the Medicare Managed Care Manual and Prescription Drug Benefit Program Manual	Compliance Program Policy and Guidance
To search federal regulations cited in this Compliance Guide	US Code of Federal Regulations
To search the US Office of Inspector General's List of Excluded Individuals and Entities (LEIE)	OIG exclusion search
To search the General Service Administration's System for Award Management (SAM)	SAM exclusion search
To search the Office of Foreign Assets Control (OFAC)	OFAC exclusion search
To search federal regulations cited in this Compliance Guide	US Code of Federal Regulations
To submit routine questions pertaining to WellSense's compliance program and/or requirements	Compliance@wellsense.org Medicare.Compliance@wellsense.org
To report non-compliance or potential FWA	**WellSense Compliance Hotline:** 888-411-4959 **WellSense Compliance:** compliance@wellsense.org **WellSense SIU:** fraudandabuse@wellsense.org

To submit routine questions pertaining to WellSense organizational policies	Supplier.Management@wellsense.org
To submit routine questions pertaining to WellSense exclusion screening processes	Exclusion.Screening@wellsense.org
Plan mailing address for notices and/or other communications	100 City Square Suite 200 Charlestown, MA 02129

Revision and Approval History

Review Date	Summary of Changes	WellSense Compliance Committee Review and Effective Date
Q1 2022	Initial Draft	April 26, 2022
Q4 2023	Annual review with no material changes	January 16, 2024
Q4 2024	Expanded scope to include state Medicaid suppliers; other non-material edits.	January 21, 2025

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