Medicaid Business Unit
Policies and Procedures

Section (Primary Department) **Medicaid Special Investigations Unit**		**SUBJECT (Document Title)** **Fraud, Waste, and Abuse Detection and Prevention in Health Plan Operations**	
Effective Date 09/26/2008	**Date of Last Review** 01/30/2015	**Date of Last Revision** 01/30/2015	**Dept. Approval Date** 01/30/2015
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Policy applies to Medicaid products offered by health plans operating in the following State(s)

California	**X**	**Louisiana**	**X**	**South Carolina**	**X**
Florida	**X**	**Maryland**	**X**	**Tennessee**	**X**
Georgia	**X**	**Massachusetts**		**Texas**	**X**
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Kentucky	**X**	**New York**	**X**	**Wisconsin**	**X**
				West Virginia	**X**

POLICY:

Summaries of the false claims statutory provisions of the U.S. and for each of the states in which Medicaid Business Unit ("MBU") operates health care plans are attached to this policy or may be obtained from Medicaid Special Investigations Unit ("MSIU"), a Plan Compliance Officer or Medicaid Compliance Governance ("MCG"), formerly known as the Office of Business Ethics.

To outline MBU programs, policies and procedures established to prevent, detect, mitigate, and, where appropriate, disclose, fraud, waste, and abuse by the company, its associates, and contractors as well as by third parties including providers and Health Plan members.

MBU, its associates and contractors, and the Company's shared services departments which support the MBU in the operation of its government-sponsored business, have an affirmative obligation to participate in efforts to prevent, detect, and mitigate fraud, waste and abuse in the health care system. This also includes an obligation to report instances of suspected fraud, waste or abuse to government authorities, where appropriate.

More specifically, MBU, and shared services departments which support the MBU, its subsidiaries, and associates, and contractors are expressly prohibited from:

1) presenting a claim for payment under the Medicaid programs knowing that such claim is false or fraudulent;
2) presenting a claim for payment under the Medicaid programs knowing that the person receiving a Medicaid benefit or payment is not authorized or is not eligible for such benefit;
3) making or using a false record or statement to obtain payment from a Medicaid program while knowing that such record or statement is false;
4) making or using a record or statement to conceal, avoid or decrease an obligation to make a payment to a Medicaid program, knowing that such record or statement is false;
5) knowingly making a claim under the Medicaid program for a service or product that was not provided;

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6) not repaying (within sixty (60) days of confirmation) a false or fraudulent claim to the government; or
7) retaining funds improperly or erroneously paid to the Company by a federal health care program.

In addition, MBU has an affirmative obligation to undertake diligent efforts to detect fraud, waste and abuse by health plan members, providers and other persons in the operations of its health plans.

DEFINITIONS:

Abuse – includes practices that are inconsistent with sound fiscal, business or medical practices, and that result in the unnecessary cost to the government healthcare program, or in reimbursement for services medically unnecessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary costs to the healthcare program.

Fraud - includes any deception or misrepresentation committed intentionally, through deliberate ignorance, or reckless disregard by a person or entity in order to receive benefits or funds to which they are not entitled. This may include deception by prospective members seeking to join a health plan, improper coding or other false statements by providers seeking reimbursement from MBU, or false representations or other violations of federal health care program requirements by MBU, its associates, or contractors.

Knowingly – means that a person, with respect to information, has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information.

Overpayment – means any funds that the MBU and/or one of its health plans receives or retains under a federally-sponsored healthcare program, e.g. Medicaid, to which the MBU and/or the health plan in question, after appropriate reconciliation, is not entitled.

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Waste – includes over-utilization of services not caused by criminally negligent actions; waste also involves the misuse of resources.

PROCEDURE:

1) Fraud, waste or abuse by MBU, and shared services departments which support the MBU, its associates or Contractors.
   a) MBU has established a number of compliance resources to assist in the prevention, detection, mitigation, and disclosure of violations of law, the Standards of Ethical Business Conduct, and Company policies and procedures, or other forms of fraud, waste and abuse. These include:
      i) Standards of Ethical Business Conduct ("Code");
      ii) Compliance Program Computer-Based Training Modules;
      iii) Medicaid Compliance Governance;
      iv) The Medicaid Special Investigations Unit Department; and
      v) The Internal Audit Department.

      Copies of the Code and other compliance or internal controls-related policies and procedures can be found on the Medicaid Compliance website accessed through Heartbeat and/or WorkNet.
   b) All associates and certain contractors[1] are required to complete two hours of general compliance training within thirty (30) days of hire, including a specific module addressing their responsibilities for preventing, detecting, and mitigating fraud, waste and abuse.
2) Fraud, waste or abuse by Providers and Health Plan Members.

MBU has created the MSIU to:

   a) implement systems for identifying patterns or instances of suspicious provider or member activity; and
   b) receive reports of provider or member misconduct from other Company and external sources.

[1] These include contractors who engage directly in marketing or enrollment activities or who prepare or submit claims for payment by federal health care programs (e.g., Medicaid and Medicare) on behalf of the Company.

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Evidence of misconduct or suspicious provider or member activities are investigated by the MSIU in coordination with other appropriate departments. The MSIU coordinates with other departments and state or federal agencies, as appropriate, to report and resolve confirmed instances of fraud, waste, abuse or other misconduct, including recommendations for corrective actions and improvements to internal controls.

In addition, MBU has created a Provider Billing Integrity (PBI) program. The PBI program identifies aberrant provider billing practices by analyzing medical trends and billed procedure codes for providers whose billing/utilization practices are markedly different from their peers. Once identified, these providers are made aware of their aberrant behavior and provided educational information, including proper coding instructions. Provider behavior is monitored and, if the coding patterns are unchanged or inadequate responses received, a provider may be subject to post payment or pre-payment claims review. Referrals may also be made to MSIU based upon provider response and claims review findings.

3) Reporting obligations.

MBU , and shared services departments which support the MBU, associates and contractors have an affirmative obligation to report suspected violations of law, the Code, Company policies and procedures, or other forms of fraud, waste or abuse to appropriate Company personnel, including a supervisor or manager, the Medicaid Compliance Officer, a Plan Compliance Officer, Medicaid Compliance Governance, MSIU, or the Internal Audit Department. MBU maintains anonymous hotlines for reporting suspected fraud, waste and abuse. The reporting requirements are outlined in the Duty to Report Suspected Compliance Issues and Non-Retaliation policy. In addition to the anonymous hotlines, MSIU maintains an email address on the internal email system at medicaidfraud@anthem.com.

MBU will maintain the confidentiality of any person who files a report of suspected fraud, waste or abuse or participates in a subsequent investigation of the report to the extent allowed by law.

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Kentucky	**X**	**New York**	**X**	**Wisconsin**	**X**
				West Virginia	**X**

Where required by law or contract requirements, MBU will disclose instances of potential fraud, waste or abuse to appropriate government agencies through the MCG, the MSIU , the Medicaid Compliance Officer, or Legal.

4) Non-retaliation.

MBU, , and shared services departments which support the MBU, its associates and contractors are prohibited from taking any retaliatory action against any person who provides a good faith report of unlawful activity or other form of fraud, waste or abuse or who participates in any internal or external investigations of such reports. Retaliation is also prohibited against any person who files and/or participates in a whistleblower suit brought under the federal or any state false claims act.

REFERENCES:

Attachment A - State False Claims Act Summaries

Related Policies and Procedures

Standards of Ethical Business Conduct
Reporting Ethics and Compliance Issues
Investigations of Reported Ethics and Compliance Issues
Non-Retaliation/Whistleblowers/Workforce Member Crime Victims
Compliance Investigations
New Associate Ethics and Compliance Training

Related Materials

EPIC (Ethics, Privacy, Information Security, Compliance) New Hire Training
Introduction to Healthcare Fraud, Waste and Abuse Training
I Am…Anthem Refresher Training
Annual Fraud Plan
Fraud and Abuse Red Flags Checklists and Guidelines

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Georgia	**X**	**New Jersey**	**X**	**Texas**	**X**
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Louisiana	**X**	**New York**	**X**	**Wisconsin**	**X**
				West Virginia	**X**

RESPONSIBLE DEPARTMENTS:

Primary Department:
Medicaid Special Investigations Unit

Secondary Department(s):
Medicaid Compliance Governance

EXCEPTIONS:

Attachment - A

SUMMARY OF STATE FALSE CLAIMS STATUTES

California. DHCS - Exhibit E, Attachment 2, Section 26.C. Federal False Claim Act Compliance Contractor shall comply with 42 USC Section 1396a(a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this Contract. Upon request by DHCS, Contractor shall demonstrate compliance with this Provision, which may include providing DHCS with copies of Contractor's applicable written policies and procedures and any relevant employee handbook excerpts.

Exhibit E, Attachment 2, Section 32 Federal False Claims Act Compliance
Effective January 1, 2007, Contractor shall comply with 42USC Section 1396a(a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this Contract. Upon request by DHCS, Contractor shall demonstrate compliance with this provision, which may include providing DHCS with copies of Contactor's applicable written policies and procedures and any relevant employee handbook excerpts.

CMSP – Not Addressed
AIM – Not Addressed
MRMIP – Not Addressed

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Indiana	**X**	**New Mexico**	**X**	**Virginia**	**X**
Kansas	**X**	**Nevada**	**X**	**Washington**	**X**
Louisiana	**X**	**New York**	**X**	**Wisconsin**	**X**
				West Virginia	**X**

References:

31 USC 3729-3733
31 USC 3801 *et seq.*
Public Law 109-171 §6032 (Deficit Reduction Act of 2005)
California Government Code, §§ 12650-12656
Anthem Medicaid All States Business Bulletin #07-76TA (9/07)

Florida. Florida has adopted false claims statutes that are intended to prevent fraud and abuse in the Florida Medicaid program. Many of the provisions are similar to the Federal Act. In general, they prohibit filing any false or fraudulent claim or documentation in order to receive compensation from the Medicaid program. The Florida Act also makes it unlawful to fail to disclose a false claim within a reasonable time after discovery, even if the original claim was inadvertent or the result of an error.

The Act includes a whistleblower provision that prevents employers from retaliating against employees who report their employer's false claims.

Georgia. Georgia has adopted a Medicaid anti-fraud statute that is intended to prevent the submission of false and fraudulent claims to the Georgia Medicaid program. The statute makes it unlawful for any person or company to submit false and fraudulent claims to the Georgia Medicaid program. Violations of the statute may be prosecuted as either civil or criminal offenses and are punishable by imprisonment and/or significant monetary penalties.

Indiana. 46. Prevention of Fraud and Abuse. In accordance with 42 U.S.C. 1396a(a)(68), Contractor shall establish and disseminate, to its employees (including management), subcontractors, and agents, written policies that provide detailed information about federal and state False Claims Acts, whistleblower protections, and Contractor policies and procedures for preventing and detecting fraud and abuse. The written policies described in this paragraph may be on paper or in electric form and must be adopted by the

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Kansas	**X**	**Nevada**	**X**	**Washington**	**X**
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subcontractors and agents of the Contractor. If Contractor maintains an employee handbook, the Contractor shall provide the described information specifically in the employee handbook. In any inspection, review, or audit of the Contractor by (or at the behest of) the State or federal government, the Contractor shall provide upon request copies of its written policies regarding fraud, waste, and abuse. Contractor shall submit to OMPP a corrective action plan within sixty days (60) if the Contractor is found not to be in compliance with any part of the requirements stated in this paragraph. If Contractor is required to submit a corrective action plan and does not do so within sixty (60) days, the state may withhold payment to the Contractor until a corrective action plan is received.

Kansas. The Kansas False Claims Act (Kansas Statutes Chapter 75, Article 75) prohibits knowingly submitting to the state a false or fraudulent claim. The Act makes it illegal to knowingly: (1) submit a false or fraudulent claim for payment or approval; (2) make or use a false statement to get the state to pay a false or fraudulent claim; (3) conspire to defraud the state by getting a false or fraudulent claim paid by the state; and (4) makes or uses a false record to conceal, avoid, or decrease an obligation to pay the state. Other prohibited conduct relates to the inappropriate use of public property or money. The Act also prohibits employers from retaliating against employees for bringing a lawsuit under the Act or providing information to the state to promote enforcement of the statute.

Violation of the Act is punishable by monetary penalties. A person bringing a lawsuit on behalf of the state under the Act may receive between 15% and 30% of the proceeds obtained through the suit.

Kentucky. KRS 205.8451 to 205.8483, Control of Fraud and Abuse, include provisions for restitution and treble damages in an administrative process where a provider is found to be liable. Fraudulent acts and penalties are described at KRS 205.8463.

Louisiana. The Louisiana False Claim Act may be called the "Medical Assistance Programs Integrity Law". This Act was enacted to combat and prevent fraud and abuse committed by some health care providers participating in the medical assistance programs and by other

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persons and to negate the adverse effects such activities have on fiscal and programmatic integrity.

The legislature intends the secretary of the Department of Health and Hospitals, the attorney general, and private citizens of Louisiana to be agents of this state with the ability, authority, and resources to pursue civil monetary penalties, liquidated damages, or other remedies to protect the fiscal and programmatic integrity of the medical assistance programs from health care providers and other persons who engage in fraud, misrepresentation, abuse, or other ill practices, as set forth in this Part, to obtain payments to which these health care providers or persons are not entitled.

No person shall knowingly present or cause to be presented a false or fraudulent claim, engage in misrepresentation to obtain, or attempt to obtain, payment from medical assistance programs funds, make, use, or cause to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the medical assistance programs, conspire to defraud, or attempt to defraud, the medical assistance programs through misrepresentation or by obtaining, or attempting to obtain, payment for a false or fraudulent claim, or submit a claim for goods, services, or supplies which were medically unnecessary or which were of substandard quality or quantity.
If a managed care health care provider or a health care provider operating under a voucher system under the medical assistance programs fails to provide medically necessary goods, services, or supplies or goods, services, or supplies which are of substandard quality or quantity to a recipient, and those goods, services, or supplies are covered under the managed care contract or voucher contract with the medical assistance programs, such failure shall constitute a violation.

Maryland. Maryland has adopted false claims statutes that are intended to prevent fraud and abuse in the Maryland Medicaid program. Many of the provisions are similar to the Federal Act. In general, they prohibit filing any false or fraudulent claim or documentation in order to receive compensation from the Medicaid program. The Maryland Act also makes it unlawful

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to fail to disclose a false claim within a reasonable time after discovery, even if the original claim was inadvertent or the result of an error.

The Act includes a whistleblower provision that prevents employers from retaliating against employees who report their employer's false claims.

Nevada. Nevada has adopted false claims statutes that are intended to prevent fraud and abuse in the Nevada Medicaid program. Many of the provisions are similar to the Federal Act. In general, they prohibit filing any false or fraudulent claim or documentation in order to receive compensation from the Medicaid program. The Nevada Act also makes it unlawful to fail to disclose a false claim within a reasonable time after discovery, even if the original claim was inadvertent or the result of an error.

The Act includes a whistleblower provision that prevents employers from retaliating against employees who report their employer's false claims. NRS § 357.010 et seq. and NRS § 422.540

New Jersey. The New Jersey False Claims Act prohibits knowingly submitting to the state a false or fraudulent claim. The Act makes it illegal to knowingly: (i) submit a false or fraudulent claim for payment or approval; (ii) make or use a false statement to get the state to pay a false or fraudulent claim; (iii) conspire to defraud the state by getting a false or fraudulent claim paid by the state; and (iv) makes or uses a false record to conceal, avoid, or decrease an obligation to pay the state. Other prohibited conduct relates to the inappropriate use of public property or money. The Act also prohibits employers from retaliating against employees for bringing a lawsuit under the Act or providing information to the state to promote enforcement of the statute.

Violation of the Act is punishable by monetary penalties. A person bringing a lawsuit on behalf of the state under the Act may receive between 15% and 30% of the proceeds obtained through the suit.

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There are additional NJ State specific requirements related to fraud, waste and abuse. For details on these requirements, please see the New Jersey health plan P&P "New Jersey Fraud, Waste and Abuse Prevention & Detection."

New York. The New York False Claims Act makes it illegal to knowingly: (i) submit a false or fraudulent claim to the state for payment or approval; (ii) make or use a false statement to get the state to pay a false or fraudulent claim; (iii) conspire to defraud the state by getting a false or fraudulent claim paid by the state; and (iv) make or use a false record to conceal, avoid, or decrease an obligation to pay the state. Other prohibited conduct relates to the inappropriate use of public property or money.

Violations of the Act are punishable by significant monetary penalties payable to the state and/or local governments. The Act also contains remedies for employees who are subjected to retaliation by an employer for bringing an action under the statute.

South Carolina. Contract, 13 TERMS AND CONDITIONS **13.41 Employee Education about False Claims Recovery** If the Contractor receives annual Medicaid payments of at least $5,000,000, the Contractor must comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005.

Tennessee. Tennessee has adopted false claims statutes that are intended to prevent fraud and abuse in a state Medicaid program, including TennCare. Many of the provisions are similar to the Federal Act. In general, they prohibit filing of false or fraudulent claims or documentation in order to receive compensation from the Medicaid program. The Tennessee Act also makes it unlawful to fail to disclose a false claim within a reasonable time after discovery, even if the original claim was inadvertent or the result of an error.

The Act includes a whistleblower provision that prevents employers from retaliating against employees who report their employer's false claims.

Texas. Texas has adopted false claims statutes that are intended to prevent fraud and abuse in the Texas Medicaid program. Many of the provisions are similar to the Federal Act. Texas

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statutes however do not currently follow Federal statute of limitation guidelines for retaliation or Qui Tam actions but are being reviewed for subsequent amendment to fall into compliance. In general, they prohibit filing any false or fraudulent claim or documentation in order to receive compensation from the Medicaid program. The Texas Act also makes it unlawful to fail to disclose a false claim within a reasonable time after discovery, even if the original claim was inadvertent or the result of an error.

The Act includes a whistleblower provision that prevents employers from retaliating against employees who report their employer's false claims.

Virginia. Virginia has adopted a false claims act to prevent fraud and abuse in the Commonwealth of Virginia, including within its Medicaid program. Many of the provisions are similar to the Federal Act. In general, they prohibit filing any false or fraudulent claim or documentation in order to receive compensation from the Medicaid program.

The Act includes a whistleblower provision that prevents employers from retaliating against employees who report their employer's false claims.

Virginia Fraud Against Taxpayers Act, Va. Code §§ 8.01-216.1 through 8.01-216.19

Washington. In 2012, the Washington State legislature passed SB 5978 amending the Fraudulent Practices Act, RCW 74.09.10, to enlist private whistleblowers in the state's efforts to save taxpayer dollars:

1. Authorizes whistleblowers to bring claims in the name of the government against individual or corporate fraudsters;

2. Provides for whistleblower awards of between 15 and 30 percent of the government's recovery;

3. Extends anti-retaliation relief to whistleblowers harmed by employers or others who retaliate. Employees and independent contractors who are demoted, discharged,

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Indiana	**X**	**New Mexico**	**X**	**Virginia**	**X**
Kansas	**X**	**Nevada**	**X**	**Washington**	**X**
Louisiana	**X**	**New York**	**X**	**Wisconsin**	**X**
				West Virginia	**X**

suspended, threatened, harassed, or in any other manner discriminated against by anyone in the terms and conditions of employment in response to their efforts to blow the whistle can sue separately for lost wages, reinstatement, attorney fees and litigation costs.

RCW 74.09.210 outlines penalties for fraudulent practices.

Washington's Medicaid FCA will sunset at the end of 2016 unless renewed at that time.

West Virginia. ARTICLE III, Section 2. Provider Network 2.1 OTHER REQUIREMENTS
MCO Provider Contract Requirements
12. Requirement to comply with Section 6032 of the Deficit Reduction Act of 2005, if the network provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources). A provider must: 1. Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A). 2. Include as part of such written policies detailed provisions regarding the network provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse. 3. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse

Article III, Section 8. Additional Requirements 8.1 Fraud and Abuse Guidelines
False Claims Acts

BACKGROUND:
Fraud is a serious problem for the U. S. health care system and adds billions of dollars of unnecessary cost each year. To address this challenge, the federal government and many

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Effective Date 09/26/2008	**Date of Last Review** 01/30/2015	**Date of Last Revision**	**Dept. Approval Date**
Department Approval/Signature :			

Policy applies to health plans operating state-sponsored business in the following State(s)

California	**X**	**Massachusetts**	**X**	**South Carolina**	**X**
Florida	**X**	**Maryland**	**X**	**Tennessee**	**X**
Georgia	**X**	**New Jersey**	**X**	**Texas**	**X**
Indiana	**X**	**New Mexico**	**X**	**Virginia**	**X**
Kansas	**X**	**Nevada**	**X**	**Washington**	**X**
Louisiana	**X**	**New York**	**X**	**Wisconsin**	**X**
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state governments have amended or enacted false claims laws and/or anti-kickback laws to permit criminal and civil prosecutions of improper and wasteful health care practices.

The Federal False Claims Act prohibits the knowing submission of a false or fraudulent claim for payment to the federal government. It also prohibits the use of false statements or records for the purpose of obtaining an improper payment or concealing the receipt of such a payment. The Act applies to all claims for payment of items or services furnished to a beneficiary of Medicare, Medicaid, or other federally-financed health care program, including payments received by Medicare or Medicaid managed care organizations. It also applies to certain claims-related filings and reports including cost and encounter data reports. The term "knowing" includes actual knowledge that a claim or statement is false, made in deliberate ignorance of the truth or falsity of a claim or statement or made with reckless disregard for the truth or falsity of a claim or statement. This does not include honest mistakes or errors, but it may include failure to implement adequate measures to ensure the accuracy of claims or statements or failure to undertake prompt remedial steps to correct improper claims or statements once they are discovered.

Civil penalties for violations of the Act can include:

1) Civil penalties of up to three times the value of any improper payments received as the result of a false claim or statement, plus
2) Additional civil penalties of $5,500 to $11,000 per false claim.

Additional administrative sanctions may be imposed by the Office of Inspector General for the submission of false statements and or claims including penalties of not more than $5,500 per false claim and suspension or exclusion from federal healthcare programs.

The Act also authorizes private "whistleblowers" to file lawsuits against health care providers and other entities, including a managed care organization, for alleged false claims. The federal government has the option to join the suit or to let the original whistleblower pursue the

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matter on his or her own. If a suit ultimately results in the recovery of improper payments, the whistleblower may be awarded a percentage of the amount recovered. A whistleblower's share may be reduced or eliminated if he or she is found to have planned or participated in the false claims violation. The FCA requires repayment of overpayments, including but not limited to those made in connection with false and fraudulent claims made to the government within the later of sixty (60) days of identifying the overpayment2 or the date the corresponding cost report is due, if applicable. Certain states (including the State of New York, Office of Medicaid or OMIG) have adopted a similar repayment policy.

The Act specifically prohibits retaliation against an employee who files a whistleblower suit. An employee may not be discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against in his or her employment as a result of filing a false claims action or cooperating in a government investigation. The whistleblower may be entitled to reinstatement, two times the amount of back pay owed, plus interest, and other compensation such as litigation costs and attorney's fees.
A number of similar State False Claims Acts have been adopted covering claims and statements relating to state government payments. These generally include items and services furnished to state Medicaid beneficiaries or beneficiaries of other state sponsored health care programs, including health-related managed care contracts. Penalties for violation of state false claims acts vary, but are generally designed to be large enough to pose a significant deterrent to fraudulent behavior. Many state acts also include whistleblower provisions and protections.

Pursuant to Section 6032 of the Deficit Reduction Act of 2005, any entity who receives or makes Title XIX (Medicaid) payments of at least $5,000,000 annually must establish written or electronic policies and procedures for the education of employees of affected entities regarding false claims recoveries.

[2] Any funds that the MBU and/or one of its health plans receives or retains under a federally-sponsored healthcare program, e.g. Medicaid, to which the MBU and/or the health plan in question, after appropriate reconciliation, is not entitled.

Medicaid Business Unit
Policies and Procedures

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Louisiana	**X**	**New York**	**X**	**Wisconsin**	**X**
				West Virginia	**X**

REVISION HISTORY:

Review Date	Changes
1/28/14	• Annual review by OCC. Moved to MBU template. Revisions to entire P&P.
10/8/14	• Removed Office of Business Ethics references and replaced with Medicaid Compliance Governance, added CA requirements, updated primary owner to Medicaid Special Investigations Unit
1/30/15	• Annual review. Add references for Kentucky.