POLICY TITLE: COMPLIANCE REVIEWS AND INVESTIGATIONS FOR REPORTING	POLICY # 9.7	
Topic Area: CORPORATE COMPLIANCE **Applies to:** LRE Staff and Operations **Developed and Maintained by:** CEO and Designee **Supersedes:** N/A	**ISSUED BY:** Chief Compliance Officer **APPROVED BY:** Board of Directors	**REVIEW DATES** 8/21/14 — 7/22/22 7/21/23 **Effective Date:** January 1, 2014 — **Revised Date:** 2/17/25

I. PURPOSE

To articulate the process that will be used by LRE regionally in all managed care compliance investigations. To ensure LRE staff and its provider network report suspected violations, misconduct and Medicaid fraud, waste, and abuse, complete investigations, and complete the required reporting in accordance with the Compliance Plan, Compliance Reporting, and Ongoing Communications.

II. POLICY

Lakeshore Regional Entity's (LRE) Compliance Officer will coordinate and complete the investigation of all LRE Medicaid fraud, abuse, or waste compliance allegations throughout the LRE region and provider network.

A. Suspected Medicaid Fraud, Waste, and/or Abuse:

1. LRE staff and its Provider Network shall report all suspected Medicaid fraud, waste, and abuse to the LRE Corporate Compliance Officer in accordance with standards established in the LRE Compliance Plan. Investigations shall be conducted in accordance with the LRE Compliance Plan, Compliance Reporting, and Ongoing Communication.
2. Reports will be made to the LRE Corporate Compliance Officer in writing utilizing the Office of Inspector General Fraud Referral Form.
3. LRE's Compliance Officer will complete a preliminary investigation, as needed, to determine if a suspicion of fraud exists.
4. If there is suspicion of fraud, LRE's Compliance Officer will report the suspected fraud and abuse to the MDHHS Office of Inspector General.
5. LRE's Corporate Compliance Officer will inform the appropriate provider network member when a report is made to the Michigan Department of Health and Human Services (MDHHS) Office of Inspector General (OIG).
6. LRE will follow the guidance/direction provided by the MDHHS Office of Inspector General regarding investigation and/or other necessary follow up.
7. Corrective action plans developed by the Provider Network, shall be submitted to the LRE Corporate Compliance Officer within thirty (30) days of the approved plan.

8. The LRE Corporate Compliance Officer shall review corrective action plans and ensure, as appropriate, prompt restitution of any overpayment amounts, notifying the appropriate governmental agency, coordinating with the CMHSP designee for follow-up monitoring and oversight, and implementing system changes to prevent a similar violation from recurring in the future.

B. Suspected Violations and/or Misconduct (not involving Medicaid Fraud and/or Abuse):
   1. LRE staff shall report all suspected violations and/or misconduct to the LRE Corporate Compliance Officer.
   2. Reporting and Investigations shall be conducted in accordance with the LRE Compliance Plan, Compliance Reporting, and Ongoing Communications.
   3. Where internal investigation substantiates a reported violation, corrective action plans will be initiated by LRE staff.

C. Required Reporting:
   1. LRE's Provider Network shall submit compliance activity reports quarterly to the LRE Corporate Compliance Officer utilizing the Office of Inspector General program integrity report template. Minimally the report will include the following:
      a. Tips/grievances received
      b. Data mining and analysis of paid claims, including audits performed based on the results
      c. Audits performed
      d. Overpayments collected
      e. Identification and investigation of fraud, waste, and abuse (as these terms are defined in the "Definitions" section of this contract
      f. Corrective action plans implemented
      g. Provider dis-enrollments
      h. Contract terminations

   2. Reporting Period/Due Dates to LRE:
      - January through March: April 30
      - April through June: July 31
      - July through September: October 31
      - October through December: January 31

D. The LRE Corporate Compliance Officer will prepare a quarterly summary report of the Provider Network and direct LRE compliance activities and present to the LRE Compliance Committee and Regional Compliance Committee. An annual summary

report of the regional compliance activities will be presented to the LRE Board of Directors.

E. To the extent consistent with applicable law, including but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, the PIHP is required to comply with MDHHS-OIG's requests for documentation and information related to program integrity and compliance.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to all LRE staff and operations.

IV. MONITORING AND REVIEW

The Chief Executive Officer and designee will review this policy on an annual basis

V. DEFINITIONS

Compliance investigation: the observation or study of suspected fraud, abuse, waste, or reported violations of applicable laws and regulations for all Lakeshore Regional Entity covered services by close examination and systematic inquiry**.**

Abuse: means provider practices that are inconsistent with sound fiscal, business, or clinical practices, and result in an unnecessary cost to the Medicaid programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid programs.

Fraud (per 42 CFR): means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law including but not limited to the Federal False Claims Act and the Michigan False Claims Act.

Fraud (per Michigan statute and case law interpreting same): Under Michigan law, a finding of Medicaid fraud can be based upon evidence that a person "should have been aware that the nature of his or her conduct constituted a false claim for Medicaid benefits, akin to constructive knowledge." But errors or mistakes do not constitute "knowing" conduct necessary to establish Medicaid fraud, unless the person's "course of conduct indicates a systematic or persistent tendency to cause inaccuracies to be present."

Waste: means overutilization of services, or other practices that directly or indirectly result in unnecessary costs. Generally, not considered caused by criminally negligent actions, but rather the misuse of resources.

Abuse: means actions that directly or indirectly result in unnecessary costs. Abuse includes any practices that does not provide consumers with medically necessary services or meet professionally recognized standards. It can also include billing for services that are not medically necessary.

VI. RELATED POLICIES AND PROCEDURES

A. Corporate Compliance Plan
B. Compliance Policies and Procedures

VII. REFERENCES/LEGAL AUTHORITY

A. 42 Code of Federal Regulations 455.17 – Reporting Requirements
B. 42 Code of Federal Regulations 438.608: Program Integrity Requirement
C. 42 Code of Federal Regulations, Part 2: Confidentiality of Substance Use Disorder Patient Records
D. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY20 contract, Attachment P 7.7.1.1: PIHP Reporting Requirements
E. Michigan Mental Health Code

VIII. ATTACHMENTS

A. LRE Compliance Investigation Reports Office of Inspector General Fraud Referral Form
B. LRE Compliance Activity Report Template

IX. CHANGE LOG

Date of Change	Description of Change	Responsible Party
08/21/2014	New Policy	Chief Compliance Officer
7/22/2023	Annual Review-	CEO and Designee
2/17/2025	Annual Review: added references to waste throughout the policy and a definition of abuse. Moved policies regarding corrective action to appropriate section.	CEO and Designee