SMMC Managed Care Plan Report Guide
Quarterly Fraud and Abuse Activity Report Summary

02/01/2025

BENEFIT TYPE(S):

The Managed Care Plan providing the following benefit type(s) must submit this report:

- ☒ LTC
- ☒ MMA & MMA Specialty
- ☒ Dental

REPORT PURPOSE:

The purpose of this report is to provide the Agency's Office of Medicaid Program Integrity (MPI), with a quarterly ongoing comprehensive fraud and abuse prevention activity report from the Managed Care Plan regarding their investigative, preventive, and detective activity efforts. By way of this report, the Managed Care Plan shall demonstrate its due diligence for fraud and abuse compliance, including utilization control; to safeguard against unnecessary or inappropriate use of Medicaid services, excess payments, and underutilization; assess quality, and take necessary corrective action to ensure program effectiveness. This report is implemented as an adjunct tool in statewide surveillance for managed care fraud and abuse. This report is a supplemental comprehensive summary regarding the quarterly status, progression, and outcome of the Managed Care Plan's previously reported referrals (via online) of identified suspected/confirmed fraud and abuse, commonly known as the 15-day report, and of recoveries on suspected/confirmed fraud and abuse, commonly known as the 30-day report. (See Report Guide chapters: Suspected/Confirmed Fraud and Abuse Reporting and Suspected/Confirmed Recovered Fraud and Abuse Reporting).

Note: This summary report does not replace the Managed Care Plan's requirement to report all identified suspected/confirmed fraud and abuse within 15 calendar days of detection, or its requirement to report all overpayments recovered from suspected/confirmed fraud and abuse within 30 calendar days of recovery (commonly known as the 30-day report), to Medicaid Program Integrity in accordance with contractual and statutory requirements.

See also in Report Guide: Suspected/Confirmed Fraud and Abuse Reporting and Suspected/Confirmed Recovered Fraud and Abuse Reporting.

FREQUENCY & DUE DATES:

Report Year Type	Report Year Period
S = State	07/01 – 06/30

Report Frequency	Reporting Data Period
Q = Quarterly	Two digits for quarter of data being reported (01, 02, 03, 04)

This report is due quarterly, within fifteen (15) calendar days after the end of the quarter being reported.

REPORT CODE & SUBMISSION:

Report Code	0195

To comply with the Quarterly Fraud and Abuse Activity Report (QFAAR) requirements, the Managed Care Plan must submit the following via the Agency's Office of Medicaid Program

Integrity's MPI-MCU SFTP site to the Reports subfolder in the Managed Care Plan specific file folder (see paragraph 5 of the Instructions section for more information), using the file naming convention described in Chapter 2:

- The template provided with all required fields completed, and
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

Note: New records must be entered in the same fiscal year quarter as the date identified fraud and abuse was reported to MPI using the online report form, commonly known as the 15-day report. The Managed Care Plan must be aware of the need to reconcile numbers reported to MPI and be able to provide explanations for any variances and discrepancies between reports and reported numbers (See Report Guide chapters "Annual Fraud, Waste and Abuse Activity Report", "Quarterly Fraud and Abuse Activity Report", "Suspected/Confirmed Fraud and Abuse Report", and "Suspected/Confirmed Recovered Fraud and Abuse Report").

1. In the template provided, on the tab "Summary of Fraud and Abuse" the Managed Care Plan must provide the following information relative to the quarter's fraud and abuse activities:
    A. **Reporting State Fiscal Year:** Select the appropriate Reporting State Fiscal Year from the drop-down list for which the report is being submitted;
    B. **Reporting State Fiscal Quater:** Select the appropriate Reporting Quarter from the drop-down list for which the report is being submitted;
    C. **Medicaid Managed Care Plan:** Select the Medicaid Managed Care Plan three-character identifier from the plan identifier table in Chapter 2 from the drop-down list;
    D. **Medicaid Managed Care Plan ID(s):** Enter the Medicaid ID or IDs for which the report is being submitted;
    E. The Medicaid Managed Care Plan Vendor Names if they participate in the recoveries of Fraud and Abuse and will be reported on in this report.
    F. A summary, by quarter, of the instances of suspected/confirmed fraud and abuse identified by the Managed Care Plan, broken into categories as provided on the template;
    G. A summary, by quarter, of the recoveries, sanctions, and fines, made relative to fraud and abuse by the Managed Care Plan, broken into categories as provided on the template.

2. In the template provided, there are two tabs for each reporting quarter, one for Open cases and one for Closed cases. There are 46 columns on each tab in which the Managed Care Plan must include the following information relative to the quarter's activities regarding instances of suspected/confirmed fraud and abuse identified (**Final Overpayment Amount Identified** and **Total Dollar Amount Lost** may only be applicable on Closed cases). The key identifiers listed below must be provided for each previously reported 15-day report:
    A. **New/Previously Reported:** Select "New" if complaint was first reported to MPI during the current reporting period, or select the previously reported State Fiscal Quarter and State Fiscal Year if the 15-day report was submitted to MPI via the online complaint form (as reported in the **Date First Reported to MPI** column) prior to the current reporting period from the drop-down list;

B. **Vendor Associated (If Applicable):** Select the appropriate Vendor Type Associated from the drop-down list if applicable;
C. **MPI Complaint ID:** Indicate the 9-numeric digit MPI case tracking system Complaint ID for the issue being identified, which is provided via email by MPI after reported referral via the 15-day report. If compliant receipt confirmation from MPI has not been received within 14 calendar days of submitting the 15-day report, please contact MPIComplaints@ahca.myflorida.com with the acknowledgment number from the online form submission for assistance. This field is required;
D. **Plan Internal Tracking Number:** Indicate the Managed Care Plan Case Internal Tracking ID for the issue being identified;
E. **Provider Type (Under Review):** Select the Provider Type from the drop-down list. This should match what was reported on the 15-day report from the Provider Master List (PML) for Medicaid providers;
F. **Provider (Under Review) Tax ID:** Indicate the Provider's or Recipient's Tax Identification Number (TIN);
G. **Entity Under Review:** Select the Entity Type under review from the drop-down list;
H. **Provider/Entity Name:** Indicate the Provider or Entity Name in its entirety (including any known d/b/a), which should be in all capital letters, and the same name as the reported referral via the 15-day report from the PML for Medicaid providers;
I. **Provider/Entity Medicaid ID Number:** Indicate the 9-numeric digit Provider or Entity Medicaid ID number, if applicable (this should match what was reported on the 15-day report from the PML for Medicaid providers). If not applicable, leave field blank;
J. **Provider NPI Number (If Applicable):** Indicate the Provider or Entity National Provider Identifier (NPI), if applicable. If not applicable, leave field blank.;
K. **Date Detected:** Indicate date the issue was first detected by the Managed Care Plan in the format MM/DD/YYYY, where YYYY stands for the four-digit year, MM stands for the two-digit month, and DD stands for the two-digit day on which the issue was first detected. This date should match the date disclosed in the 15-day report;
L. **Date Reported to MPI:** Indicate date in the format MM/DD/YYYY, where YYYY stands for the four-digit year, MM stands for the two-digit month, and DD stands for the two-digit day on which the reported referral of suspected/confirmed fraud and abuse was first reported to MPI by the Managed Care Plan via the online complaint form for the 15-day report;
M. **Number of Days Until Reported:** The numeric value of number of days from **Date Detected** column to **Date 15-Day Report First Reported to MPI** column. This should be automatically calculated.
N. **Date Investigation/Audit Completed:** Indicate date in the format MM/DD/YYYY, where YYYY stands for the four-digit year, MM stands for the two-digit month, and DD stands for the two-digit day on which the investigation of the reported referral of suspected/confirmed fraud and abuse was completed.
O. **Number of Days to Complete Investigation/Audit:** The numeric value of number of days from **Date Detected** column to **Date Investigation Closed** column. This should be automatically calculated once during the life of the complaint only on complaints being reported as Closed in the **Status** column.
P. **Allegation Type:** Select whether the allegation identified is being reported as Fraud or Abuse from the drop-down list, which should be the same suspected or confirmed

allegation as the reported referral via the 15-day report (unless there was an upgrade from Abuse to Fraud);

Q. **Primary Allegation:** Select the general category of the primary allegation being reported from the drop-down list. Only select "Other" if none of the descriptions provided in the drop-down list fit the allegation. In those cases, clearly describe the allegation in the **Additional Comments for Primary Allegation** column;

R. **Secondary Allegation (If Applicable):** Select the general category of the secondary allegation reported from the drop-down list. Only select "Other" if none of the descriptions provided in the drop-down list fit the allegation. In those cases, clearly describe the allegation in the **Additional Comments for Secondary Allegation** column;

S. **Detection Tool:** Select the tool the Managed Care Plan used to detect the allegation being reported. Only select "Other" if none of the descriptions provided in the drop-down list fit the allegation. In those cases, clearly describe the allegation in the **Additional Comments for Detection Tool** column;

T. **Potential/Preliminary Overpayment Amount Identified:** Indicate the total preliminary overpayment amount identified by the Managed Care Plan through its audit/recovery activity only on initial complaints reported as "New" in the **New/Previously Reported** column. This amount should match the amount disclosed as the potential overpayment amount identified in the 15-day report and be reported only once during the life of the complaint and does not carry over from quarter to quarter;

U. **Updated Overpayment Amount Identified:** Indicate the total updated overpayment amount identified by the Managed Care Plan in the **New/Previously Reported** column, whether the amount is the same or different than potential overpayment amount previously identified in the 15-day report. This amount may be updated from quarter to quarter;

V. **Final Overpayment Amount Identified:** Indicate the total final overpayment amount identified through the Managed Care Plan's audit/recovery activity only on complaints being reported as Closed in the **Status** column. This amount should be reported regardless of whether the Managed Care Plan pursued recovery or not and only once during the life of the complaint and does not carry over from quarter to quarter;

W. **Fines Amount (If Applicable):** Indicate the total amount of all fines the Managed Care Plan imposed on the provider for the issue being reported, if applicable. This amount may be updated from quarter to quarter until the complaint is reported as closed in the **Status** column. Should the amount change from one quarter to the next, describe changes in the **Detailed Update** column;

X. **Sanctions Amount (If Applicable):** Indicate the total amount of all sanctions the Managed Care Plan imposed on the provider for the issue being reported, if applicable. This amount may be updated from quarter to quarter until the complaint is reported as closed in the **Status** column. Should the amount change from one quarter to the next, describe changes in the **Detailed Update** column;

Y. **Other Financial Penalties (If Applicable):** Indicate the total amount of other financial penalties the Managed Care Plan imposed on the provider for the issue being reported, if applicable. This amount may be updated from quarter to quarter until the complaint is reported as closed in the **Status** column. Should the amount change from one quarter to the next, describe changes in the **Detailed Update** column;

Z. **Settlement Amount (If Applicable):** Indicate the total settlement agreement amount between the Managed Care Plan and the provider, if applicable. This amount should be reported in the reported quarter that the settlement was actualized and may carry over from quarter to quarter until the complaint is reported as closed in the **Status** column. A payment plan is not a settlement amount, and description of any payment plan shall be provided in the **Detailed Update** column;

AA. **Quarter Recovery Amount (If Applicable):** Indicate the total amount recovered from the Provider through the Managed Care Plan's audit/recovery activity for the reporting period. This amount may be updated from quarter to quarter until complaint is reported as Closed in the **Status** column;

BB. **Total Recovery Amount (If Applicable):** Indicate the cumulative total amount recovered from the Provider through the Managed Care Plan's audit/recovery activity to date. This amount may be updated from quarter to quarter until complaint is reported as Closed in the **Status** column. This date should match the date disclosed in the 30-day report;

CC. **Total Dollar Amount Lost (If Applicable):** Indicate the total amount lost to the provider through its audit/recovery activity only on complaints being reported as Closed in the **Status** column. This amount should automatically calculate only once during the life of the complaint using the amount reported as **Final Overpayment Identified** less the reported **Total Recovery Amount**, and does not carry over from quarter to quarter;

DD. **Date Total Recovery Complete (If Applicable):** Indicate date in the format MM/DD/YYYY, where YYYY stands for the four-digit year, MM stands for the two-digit month, and DD stands for the two-digit day on which the total recovery amount recovered from the Provider/Entity through the Managed Care Plan's audit/recovery activity is complete and the plan is not expecting any further recovery from the Provider/Entity. This date should match the date disclosed in the 30-day report;

EE. **Number of Days to Complete Recovery (If Applicable):** The numeric value of number of days from **Date Detected** column to **Date Total Recovery Complete** column. When applicable, this should be automatically calculated.

FF. **Date Recovery Reported to MPI (If Applicable):** Indicate date in the format MM/DD/YYYY, where YYYY stands for the four-digit year, MM stands for the two-digit month, and DD stands for the two-digit day on which the recovery of suspected/confirmed fraud and abuse was first reported to MPI by the Managed Care Plan via the MPI-MCU SFTP site for the 30-day report;

GG. **Number of Days to Report Recovery to MPI (If Applicable):** The numeric value of number of days from **Date Total Recovery Complete** column to **Date Recovery Reported to MPI** column. This should be automatically calculated.

HH. **Status:** Select the complaint status as either Open or Closed, with the disposition that applies of where in the process an open investigation/audit is or what the closure outcome is from the drop-down list. Complaints should only be reported as Closed once the recovery is completely done and the plan is not expecting any further recovery from the Provider/Entity. Closed complaints must have a date entered in the **Date Investigation Closed** column. Only select "Other" if none of the descriptions provided in the drop-down list fit the complaint status. In those cases, clearly describe the complaint status in the **Additional Comments for Status** column;

II. **Other Entity Reported to Primary:** Select the other entities and/or agencies to which the Managed Care Plan has reported the complaint from the drop-down list.

The other entity columns should be reported in order of importance, with law enforcement going first, if applicable;

JJ. **Other Entity Reported to Secondary:** Select the other entities and/or agencies to which the Managed Care Plan has reported the complaint from the drop-down list in order of importance;

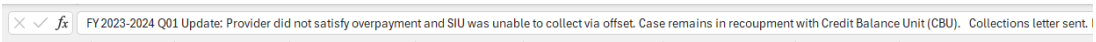
KK. **Other Entity Reported to Tertiary:** Select the other entities and/or agencies to which the Managed Care Plan has reported the complaint from the drop-down list in order of importance;

LL. **Other Entity Reported to Quaternary:** Select the other entities and/or agencies to which the Managed Care Plan has reported the complaint from the drop-down list in order of importance;

MM. **Corrective Action:** Select the type of corrective action the Managed Care Plan has taken with the provider to address the issue from the drop-down list. If a settlement agreement has been reached, that is Settlement, not Recoupment. Only select "Other" if none of the descriptions provided in the drop-down list fit the corrective action. In those cases, clearly describe the corrective action in the **Additional Comments for Corrective Action** column;

NN. **Times Provider Reviewed Within Last 5 Years:** Select the number of times the Managed Care Plan has reviewed the provider within the previous five-year period from the drop-down list;

OO. **Detailed Update:** Indicate detailed free-form narrative information related to the progression of the Managed Care Plan's review. This shall be updated from quarter to quarter (oldest to newest chronological history) to show that the review is not stagnant until the complaint is reported as closed in the **Status** column. This update should not be a summary of the Incident Description from the 15-day report. This update should include details regarding steps taken or case actions during the reported quarter and provide enough sufficient detail such that MPI will know where the Managed Care Plan is in their investigation/audit without having to request case notes. In order to complete this as requested, new quarterly updates may need to be added from the function bar.



Click in the function bar and scroll to the end to add new detailed update for the reporting quarter. Label all quarterly updates "FY YYYY-YYYY Q00 Update:", where YYYY stands for the four-digit year state fiscal year period, and 00 stands for the two digits for the quarter of data being reported (01, 02, 03, 04)

The following is an example of acceptable and unacceptable detailed updates:
Example: No action has occurred in the investigation due to medical records being under review.

- **Acceptable:** Investigator spoke with the medical reviewer on MM/DD/YYYY to receive status update. Medical reviewer states that review is approximately 50% complete, with an anticipated completion in two weeks.
- **Unacceptable:** Medical records under review;

PP. **Additional Comments for Primary Allegation:** Indicate additional details or comments relevant to the Managed Care Plan's primary allegation if "Other" was selected;

QQ. **Additional Comments for Secondary Allegation:** Indicate additional details or comments relevant to the Managed Care Plan's secondary allegation if "Other" was selected;

RR. **Additional Comments for Detection Tool:** Indicate additional details or comments relevant to the Managed Care Plan's detection tool if "Other" was selected; and

SS. **Additional Comments for Status:** Indicate additional details or comments relevant to the Managed Care Plan's Status if "Other" was selected.

TT. **Additional Comments for Corrective Action:** Indicate additional details or comments relevant to the Managed Care Plan's corrective action if "Other" was selected.

3. On the report, it is expected that a monetary value should be reported in at least one of the columns (in columns W-Y) of the report template with each quarterly submission. There may be exceptions to this; however, if the Managed Care Plan elects to not pursue an overpayment, that does not mean that the overpayment does not exist and should be reported accordingly (this scenario would show in the **Total Dollar Amount Lost** column).

4. Any additional supporting documentation to substantiate the **Detailed Update** column on the Quarterly Fraud and Abuse Activity Report shall be submitted through the MPI-MCU SFTP site as the investigation/audit progresses until cases are closed. The files should be combined into a single zip file per **MPI Complaint ID**, and named "ABC_CMPL-XXXXXXXXX_Description_MM-DD-YY", where ABC is the 3-letter plan identifier, XXXXXXXXX is MPI Complaint ID, Description is a brief explanation of submission (i.e. demand letter, investigative summary, upgrade to fraud, appeal notification, MFCU referral, etc.) and MM-DD-YY is the date of the correspondence or the date of closure of the investigation. Do not send a single zip file for multiple **MPI Complaint ID**s. This case documentation is required as the investigation/audit progresses, but no later than five (5) business days of the date reported in the **Date Investigation Closed** column for any complaints reported as Closed in the **Status** column. Once reviewed, MPI will let your plan know if further information is needed.

5. Each Managed Care Plan may have up to three (3) registered users with access to the MPI-MCU SFTP site to submit and retrieve electronic file information within each of the Managed Care Plan's specific folders (please see Annual Fraud, Waste and Abuse Activity Report Summary Chapter for additional information and user instructions).

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

AMENDMENT HISTORY:

PLAN COMMUNICATION	DATE	RECAP OF CHANGE(S)
None	**None**	**None**

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