SMMC Managed Care Plan Report Guide
Suspected/Confirmed Complete Recovery of 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 Bureau of Medicaid Program Integrity (MPI), with an ongoing comprehensive fraud and abuse activity report from the Managed Care Plan regarding their recovery efforts of suspected or confirmed instances of fraud and abuse under state and/or federal law relative to the Managed Care Plan contract and/or Florida Medicaid. Pursuant to 42 CFR § 438.608(a)(2), Managed Care Plans are required to report all overpayments recovered within thirty (30) calendar days. By way of this report, the Managed Care Plans shall demonstrate its due diligence for fraud and abuse compliance, including their efforts to protect against fraud and other overpayments, and mitigate the potential for provider overpayments to inappropriately inflate the MLR numerator. This report is a supplemental comprehensive summary regarding the recovery 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 to the Quarterly Fraud and Abuse Activity Report. (See Report Guide chapter: Suspected/Confirmed Identified Fraud and Abuse Reporting and Quarterly Fraud and Abuse Activity Report Summary). Notwithstanding any other provision of law or contract, failure to comply with these reporting requirements will be subject to sanctions.

Note: This summary report does not replace the Managed Care Plan's requirement to report all suspected/confirmed identified fraud and abuse, within 15 calendar days of detection, to Medicaid Program Integrity in accordance with contractual and statutory requirements. 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 "Complete Recovery of Fraud and Abuse Report").

FREQUENCY & DUE DATES:

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

Report Frequency	Reporting Data Period
V = Variable	Two-digit day of submission date (01-31)

The complete recovery of fraud and abuse activity report is submitted via the MPI-MCU SFTP site and is due within thirty (30) calendar days of complete recovery of overpayment.

REPORT CODE & SUBMISSION:

Report Code	0227

To comply with the Complete Recovery of Fraud and Abuse Activity Report 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 3 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:

The Managed Care Plan must report recovery of suspected or confirmed fraud and abuse relative to the Managed Care Plan's contract and Florida Medicaid. All recoveries of suspected or confirmed instances of fraud and abuse under state and/or federal law are to be reported to MPI within thirty (30) calendar days of detection by filing the provided report template.

1. In the template provided, on the tab "Summary" 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. A summary of the recoveries made relative to fraud and abuse by the Managed Care Plan, broken into categories as provided on the template.

2. In the template provided, on the tab "Recovery of Fraud and Abuse", the Managed Care Plan must include the following information relative to the activities regarding the recovery of instances of suspected/confirmed fraud and abuse identified. The template contains 18 columns of required fields, unless stated otherwise, and the key identifiers listed below must be provided for the recoveries 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. (See Report Guide chapter: Suspected/Confirmed Fraud and Abuse Reporting):
    A. **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;
    B. **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;
    C. **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;

D. **Provider NPI Number:** Indicate the Provider or Entity National Provider Identifier (NPI), if applicable. If not applicable, leave field blank;
E. **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;
F. **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;
G. **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);
H. **Potential/Preliminary Overpayment Amount Identified:** Indicate the total preliminary overpayment amount identified by the Managed Care Plan through its audit/recovery activity. This amount should match the amount disclosed as the potential overpayment amount identified on the 15-day report;
I. **Final Overpayment Amount Identified:** Indicate the total final overpayment amount identified through the Managed Care Plan's audit/recovery activity;
J. **Total Recovery Amount:** Indicate the total amount recovered from the Provider through the Managed Care Plan's audit/recovery activity;
K. **Date Total Recovery Complete:** 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 recoupment 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;
L. **Number of Days to Complete Recovery:** The numeric value of number of days from **Date Detected** column to **Date Total Recovery Complete** column. This should be automatically calculated.
M. **Date Recovery 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 recovery of suspected/confirmed fraud and abuse was first reported to MPI by the Managed Care Plan via submission of this 30-day report to the MPI-MCU SFTP site;
N. **Number of Days Until Recovery Reported:** 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.
O. **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 recoupment is completely done and the plan is not expecting any further recovery from the Provider/Entity. Only select "Other" if none of the descriptions provided in the drop-down list fit the complaint status. In those cases, and in cases in which the complaint status is Open after recoupment is complete,

clearly describe the complaint status or explanation in the **Additional Comments for Status** column;

P. **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;

Q. **Additional Comments for Status:** Indicate additional details or comments relevant to the Managed Care Plan's Status if "Open" or "Other" was selected. If not applicable, leave blank;

R. **Additional Comments for Corrective Action:** Indicate additional details or comments relevant to the Managed Care Plan's corrective action if "Other" was selected. If not applicable, leave blank.

3. 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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