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

12/18/2020

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. This report allows the Managed Care Plan to 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 suspected/confirmed fraud and abuse. (See Report Guide chapter: Suspected/Confirmed Fraud and Abuse Reporting).

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

See also: Suspected/Confirmed Fraud and Abuse Report Guide chapter.

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 MPI SFTP site:

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

INSTRUCTIONS:

Note: New records must be entered in the same fiscal year quarter as the date reported to MPI using the online fraud and abuse report form. The Managed Care Plan must be

cognizant 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 and Abuse Activity Report", "Quarterly Fraud and Abuse Activity Report", and "Suspected/Confirmed Fraud and Abuse Reporting").

The Managed Care Plan must perform the following:

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. The reporting period for which the report is being submitted;
    b. The Medicaid Managed Care Plan name for which the report is being submitted;
    c. The Medicaid Managed Care Plan Medicaid ID or IDs for which the report is being submitted;
    d. 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.
    e. 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;
    f. 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, on the tabs "Q1 Details of Fraud and Abuse", "Q2 Details of Fraud and Abuse", "Q3 Details of Fraud and Abuse", and "Q4 Details of Fraud and Abuse", the Managed Care Plan must include the following information relative to the quarter's activities regarding instances of suspected/confirmed fraud and abuse identified:
    a. Indicate the appropriate Reporting Year;
    b. Reporting Quarter;
    c. Managed Care Plan three-character identifier;
    d. Select which reporting quarter the complaint was first reported to MPI via the online complaint form;
    e. Select the Vendor Type Associated if applicable;
    f. List the MPI case tracking system Complaint Number for the issue being identified;
    g. List the Unique Managed Care Plan Case Tracking ID for the issue being identified;
    h. Select the Provider Type from drop down;
    i. List the Provider's or Recipient's Tax Identification Number (TIN);
    j. Select the Entity Type under review;
    k. State the Provider's or Entity's Name in its entirety;
    l. Indicate the reported entity's Medicaid ID number, if applicable;
    m. Indicate the reported entity's NPI, if applicable;
    n. Indicate the Date the issue was first detected by the Managed Care Plan;
    o. Indicate the Specific Date the issue was first reported to MPI by the Managed Care Plan via the online complaint form;
    p. Select whether the Allegations Type being reported is Fraud or Abuse;
    q. Select the general Category of the Primary Allegation being reported;
    r. Select the general Category of the Secondary Allegation being reported;
    s. Select the Detection Tool used to identify the issue being reported;
    t. Indicate the Preliminary Overpayment Amount identified by the Managed Care Plan;

u. Indicate the Updated Overpayment Amount identified by the Managed Care Plan;
v. Indicate the Final Overpayment Amount identified for recovery;
w. Indicate the total Amount of all Fines the plan imposed on the provider for the issue being reported, if applicable;
x. Indicate the total Amount of all Sanctions the plan imposed on the provider for the issue being reported, if applicable;
y. Indicate the total Amount of Financial Penalties the plan imposed on the provider for the issue being reported, if applicable;
z. Indicate the total Settlement Amount between the Managed Care Plan and the provider, if applicable;
aa. Indicate the total Amount Recovered from the provider through the Managed Care Plan's audit/recovery activity to date;
bb. Indicate the plan's total Amount Lost to the provider;
cc. Select the Complaint Status as either Open or Closed, with the disposition that applies;
dd. List the other Entities/Agencies to which the Managed Care Plan has reported the complaint if applicable;
ee. List the other Entities/Agencies to which the Managed Care Plan has reported the complaint if applicable;
ff. List the other Entities/Agencies to which the Managed Care Plan has reported the complaint if applicable;
gg. List the other Entities/Agencies to which the Managed Care Plan has reported the complaint if applicable;
hh. Select the type of Corrective Action the Managed Care Plan has taken with the provider;
ii. Select the Number of Times the Managed Care Plan has Reviewed the provider within the previous five-year period;
jj. Provide Detailed Information related to the progression of the Managed Care Plan's review;
kk. Provide Additional Details or Comments relevant to the Managed Care Plan's Primary Allegation if "Other" was selected;
ll. Provide Additional Details or Comments relevant to the Managed Care Plan's Secondary Allegation if "Other" was selected;
mm. Provide Additional Details or Comments relevant to the Managed Care Plan's Detection Tool if "Other" was selected;
nn. Provide Additional Details or Comments relevant to the Managed Care Plan's Status if "Other" was selected;
oo. Provide Additional Details or Comments relevant to the Managed Care Plan's Corrective Action if "Other" was selected.

3. The Managed Care Plan's Contract Manager must obtain access to the MPI SFTP site through the Agency's MPI Business Manager (or designated representative) to upload electronic file (supplemental) documentation (See Annual Fraud and Abuse Report chapter for access instructions).

4. The registered user (Managed Care Plan Contract Manager) will be notified by email in the event of an account lock out due to multiple, incorrect password attempts. The primary account holder (Managed Care Plan Contract Manager) will be notified by email when the account has been locked. The account lockout will last for 30 minutes, and then it will be

automatically cleared by the system. Users can have the block cleared immediately by contacting their AHCA MPI-MC Site Administrator (MPI Business Manager) at 850-412-4600.

5. Entering the incorrect username (i.e. a username that does not exist) will cause the user's IP address to be blocked. For the IP address block to take place, the user must attempt to connect with the incorrect username more than five times in sixty (60) seconds. The external user must contact the AHCA Site Administrator (MPI Business Manager) for MPI reporting at MPI-MCU@ahca.myflorida.com or 850-412-4600 to resolve this issue.

6. Termination of access is required in instances where there is a change of responsibilities or employee termination. A request to terminate a user's access must be submitted by the Managed Care Plan Contract Manager and must include the user's full name, position title, and business email address. The Managed Care Plan must submit the request by email to MPI-MCU@ahca.myflorida.com.

7. Any additional supporting documentation to the Quarterly Fraud and Abuse Activity Report must be HIPAA-compliant and may be submitted through the MPI SFTP site.

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**	No change(s) from the SMMC Report Guide 9/1/2019.

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