RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

December 9, 2015

Ms. Melinda Miguel
Chief Inspector General
Executive Office of the Governor
The Capitol
Tallahassee, FL 32300-0001

Dear Ms. Miguel:

Attached is the Agency for Health Care Administration's (Agency) 12-month status update on *CIG Report No. 2014-01 - Assessment of Managed Care Organizations' Anti-Fraud Plans,* published on December 9, 2014. The Agency is in the process of completing corrective action for the remaining three report issues. The Office of Medicaid Program Integrity (MPI) has developed written protocols and procedures for the review of anti-fraud and compliance plans, and created a plan for staff training. MPI anticipates completing all corrective action by January 2016. A description of all issues, recommendations, and the Agency's responses can be found in the attached document. The Agency's Internal Audit unit will perform another follow-up review in six months to assess the status of the efforts taken by MPI to correct all open issues.

If you have any questions regarding our response, please contact Mary Beth Sheffield, Director of Auditing, at 412-3978.

Sincerely,

Elizabeth Dudek
Secretary

ED/szg
Enclosure
cc/enc: Eric Miller, Inspector General

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Agency for Health Care Administration
Office of the Chief Inspector General
Report Title: Assessment of Managed Care Organizations' Anti-Fraud Plans
Report #: 2014-1, issued December 9, 2014
Twelve-Month Follow-up Status as of December 9, 2015

No.	Finding	Recommendation	Previous Management Response(s)	Twelve-Month Status Update	Anticipated Completion Date and Contact
1	MCOs report significantly low recovery rates for overpayments identified as fraud and abuse.	In our review of best practices, we noted Rule 353.502 of the Texas Administrative Code requires a Texas MCO to review three years of the provider's payment history as a part of their preliminary investigation of possible acts of waste, abuse, and fraud. Therefore, we recommend MPI propose statutory and contractual language that will require MCOs to review a period beyond one year when conducting preliminary reviews of fraud, abuse, and overpayments. In addition, we recommend MPI develop contract language to require MCOs to periodically report (e.g. annually or quarterly) on the effectiveness of their SIU's performance in Florida's Medicaid program. The report should include a description of what activity is being measured, how it is being measured, how often it is being measured, and the goals or standards established for each measure. Finally, we recommend that MPI require MCOs to describe their efforts taken to recover the identified overpayments and provide the reasons why remaining overpayments could not be recovered. This information can be provided as a supplement to the AFAAR.	**Status as of June 9, 2015:** Completed. Regarding the recommendation that MPI propose statutory and contractual language that will require MCOs to review a period beyond one year when conducting preliminary reviews of fraud, abuse, and overpayments, s. 641.3155, F.S., limits an MCO's recoveries to "within 30 months after the health maintenance organization's payment of the claim. . . [and] all claims for overpayment submitted to a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 must be submitted to the provider within 12 months after the health maintenance organization's payment of the claim. . . except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234." This statutory restriction on otherwise recoverable overpayments is a disincentive for MCOs to review a period beyond one year when conducting preliminary reviews of fraud, abuse, and overpayments. MPI drafted proposed statutory language to address this disincentive and furnished the language to the Agency's Inspector General for review	Completed.	Completed.

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			and approval in 2014. The proposal served to amend s. 641.3155, Florida Statutes, and create an exception to the statutory limitations (on overpayment recover) for Medicaid MCOs. The draft language is detailed below: (5)(b) A claim for overpayment shall not be permitted beyond 30 months after the health maintenance organization's payment of a claim, except as relates to health maintenance organizations operating within the state Medicaid program, with regard to Medicaid program overpayments, and that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234. Health maintenance organizations operating within the state Medicaid program may claim an overpayment with regard to their Medicaid operations beyond 30 months after payment of claim, not to exceed 60 months from the date of service, except that claims for overpayment may be sought beyond that time from provider convicted of fraud. (16) Notwithstanding the 30-month period provided in subsection (5), all claims for overpayment submitted to a provider licensed under chapter 458,		

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			chapter 459, chapter 460, chapter 461, or chapter 466 must be submitted to the provider within 12 months after the health maintenance organization's payment of the claim. A claim for overpayment may not be permitted beyond 12 months after the health maintenance organization's payment of a claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234. This limitation does not apply to Medicaid overpayments regarding health maintenance organizations operating within the state Medicaid program. The approved language is being submitted to the Agency's Legislative Affairs Office for consideration at the next regular session of the Florida Legislature. Ultimately, however, the Agency does not control the statute amendment process and is dependent upon the Legislature to agree with and process any statutory changes. Such recommended language was not advanced in the 2014 Regular Session. Additionally, on May 26, 2015, the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that is more than 600-pages in length. The		

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			proposed rule directly impacts managed care regulations and overpayment recoveries. Although not final, the proposed rule is likely to have a direct impact on the issue of overpayment recoveries, the expectations on the States and their Medicaid health plans, and the manner in which overpayments are taken into account in the determination of capitation rates. Regarding the recommendation that MPI require MCOs to describe their efforts taken to recover identified overpayments and provide reasons for unrecovered overpayments, effective January 1, 2015, the MCO Contract "Report Guide" required that MCOs furnish additional information regarding overpayments identified and unrecovered and why outstanding overpayments could not be recovered. This information is now published in the Report Guide, found at page 36 of 119 of the following: http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/SMMC_Report_Guide_Final_Effective_2015-01-01.pdf. *Anticipated Completion Date:* Completed		

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			Status as of December 9, 2014: The Agency concurs with the finding. In order to implement an extended mandatory review period for MCOs when MCOs are conducting preliminary reviews of fraud, abuse, and overpayments and having such extended review period result in collectable overpayments from all provider types, statutory change to ss. 627.6131 and 641.3155, Florida Statutes would be required. An associated contract revision will be developed, based upon controlling language in ss. 627.6131 and 641.3155, Florida Statutes, and will be routed in accordance with Agency protocols. While concurring with the audit recommendation that Medicaid MCOs should be required to "periodically report (e.g. annually or quarterly) on the effectiveness of their SIU's performance in Florida's Medicaid program," it should be noted that MCO contractual provisions that take effect January 1, 2015, require MCOs to report the total amount of all dollars identified as lost to overpayment, abuse, and fraud during the State Fiscal Year being reported, total overpayments recovered, total number of referrals by the MCO to MPI and "an explanation in the narrative field describing the actual steps and efforts taken to		

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			recover the identified overpayments and …reasons why remaining overpayments could not be reported." The Agency does not believe that further contractual requirements, beyond those imposed effective January 1, 2015, are necessary to successfully gauge the effectiveness of MCO SIU performance. Regarding the recommendation that MPI require MCOs to describe their efforts taken to recover identified overpayments and provide reasons for unrecovered overpayments, as stated above, effective January 1, 2015, the MCO Contract "Report Guide" will require MCOs to furnish additional information regarding overpayments identified and unrecovered and why outstanding overpayments could not be recovered. *Anticipated Completion Date*: The Report Guide goes into effect January 1, 2015, and will partially satisfy the recommended actions. Proposed statutory changes to ss. 627.6131 and 641.3155, Florida Statutes, will be drafted after consultation with the Office of Insurance Regulation and the Department of Financial Services' Division of Insurance Fraud by May 1, 2015.		

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2	MCOs' annual and quarterly activity reports do not reconcile, calling into question the accuracy of these reports.	We recommend that MPI develop contract language that requires the MCOs to provide a reconciliation of the numbers reported on the two reports and, when applicable, provide written explanations for any variances and discrepancies between the reported numbers.	**Status as of June 9, 2015:** Completed. **Status as of December 9, 2014:** The Agency concurs with this finding. Since the audit's fieldwork was completed, the MCO Contract "Report Guide" was amended (effective January 1, 2015) to require MCOs to report QFAAR activities in the same quarter as the suspected fraud (15-day) reporting. The directions indicate the need to reconcile and explain discrepancies on page 65 of the Report Guide, which reads: *Note: New records should be entered in the same calendar quarter as the date reported to MPI using the online fraud and abuse report form. The Managed Care Plan should 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 Chapters "Annual Fraud and Abuse Activity Report", "Quarterly Fraud and Abuse Activity Report", and the "Suspected/Confirmed Fraud and Abuse Reporting.)* *Anticipated Completion Date*: January 1, 2015	Completed.	Completed.

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3	Anti-fraud plans do not always provide the information necessary to assess investigations and the reporting structure within an MCO.	We recommend that MPI develop legislation to modify Section 409.91212(1)(a), F.S. to require both a written description and chart outlining the organizational arrangement of personnel who are responsible for investigating and reporting possible overpayment, abuse, or fraud. We also recommend that MPI develop contract language requiring MCOs' anti-fraud plans include detailed information (i.e., reporting structure, lines of authority, staffing numbers, staff responsibilities, etc.) about the personnel responsible for investigating and reporting possible overpayment, abuse, or fraud in Florida's Medicaid program.	**Status as of June 9, 2015:** Completed. Regarding the recommendation that MPI develop legislation to modify Section 409.91212(1)(a), F.S. to require both a written description **and** chart outlining the organizational arrangement of personnel who are responsible for investigating and reporting possible overpayment, abuse, or fraud, MPI has subsequently met with Medicaid staff regarding the Statewide Medicaid managed Care contract revisions and it was determined that the current contract was satisfactory to require and enforce the recommended documentation. Consequently, MPI now believes neither statutory revision, nor a rule amendment, is necessary. **Status as of December 9, 2014:** The Agency concurs with this finding and will draft proposed modifications to s. 409.91212, F.S. after consultation with the Division of Medicaid, Office of Insurance Regulation, and the Department of Financial Services' Division of Insurance Fraud, by May 1, 2015. Regarding the recommendation that MPI develop contract language	Completed.	Completed.

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			requiring MCOs' anti-fraud plans to include detailed information about the MCO personnel responsible for investigating and reporting possible overpayment, abuse, or fraud in Florida's Medicaid program, MPI is currently drafting a proposed rule to clarify 409.91212 F.S., which will address this recommendation and be enforceable through sanction and contractual obligation (current Medicaid MCO contracts require compliance with related Florida Administrative Code). Currently 409.91212(1)(a), F.S., requires "*[a] written description **or** chart outlining the organizational arrangement of the plan's personnel who are responsible for the investigation and reporting of possible overpayment, abuse, or fraud." Emphasis supplied.* The Agency is drafting a proposed rule clarifying the statutory requirements imposed upon MCO SIUs to ensure that the information submitted to MPI contains the elements MPI needs to determine which FTEs are responsible for which tasks related to investigating and reporting possible overpayment, abuse, or fraud in Florida's Medicaid program. *Anticipated Completion Date*: June 1, 2015		

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4	MCOs' anti-fraud plans do not always adequately explain their systems and analytical techniques used for detecting fraud and abuse. Also, MCOs are not required to include detection and investigation procedures for possible acts of fraud committed by employees.	We recommend MPI develop contract language requiring the MCOs to provide more specific information on systems and analytical techniques that are or will be used in their detection efforts. We also recommend MPI develop contract language that explicitly requires MCOs' anti-fraud plans include detection and investigation procedures not only for providers and recipients, but also for the employees of the organization.	**Status as of June 9, 2015:** Completed. MPI has subsequently met with Medicaid staff regarding contract revisions and it was determined that the current contract was satisfactory to require the recommended documentation and activities. **Status as of December 9, 2014:** The Agency concurs with this finding. In response to the first recommendation, the Agency will draft additional contractual language to require specific information on systems and analytical techniques that are or will be used by MCOs in their fraud and abuse detection efforts. It should be recognized that the Department of Financial Services' Division of Insurance Fraud attempted to impose similar informational requirements in their administrative rules related to insurer (and MCO) anti-fraud plans (69D-2.003 and 69D-2.004) in 2006, but insurers and MCOs opposed the disclosure of such information, citing protections of such information under Florida's trade secrets laws.	Completed.	Completed.

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			Regarding the second recommendation related to Finding 4, the Agency will assess existing contract language in place to determine whether such MCO contract language could be interpreted to require current Medicaid MCOs to have policies, processes, and procedures in place for the detection and investigation of fraud and program abuse by MCO employees. Additionally, draft contract language will be submitted to the Division of Medicaid to require that MCOs' anti-fraud plans include detection and investigation procedures for potential fraud or program abuse committed by MCO employees. *Anticipated Completion Date*: March 1, 2015		
5	MCOs are not required to provide sufficient detail when reporting suspected or confirmed instances of provider or recipient Medicaid fraud or abuse.	We recommend MPI develop contract language that will require MCOs to provide additional case information similar to the information that is currently required under Texas law.	**Status as of June 9, 2015:** Completed. MPI has subsequently met with Medicaid staff regarding contract revisions and it was determined that the current contract was satisfactory to require the recommended documentation and activities. **Status as of December 9, 2014:** The Agency concurs with this finding and has improved this process since	Completed.	Completed.

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			the initiation of this audit. Current processes require the MCOs to submit case information by way of a reporting template that captures much of the recommended additional information. Currently MCOs are required to report cases of suspected fraud and abuse within 15 days of discovery. In 2013, MPI proposed legislative language to increase this reporting time from 15 to 60 days allowing the MCOs more time to investigate the suspected case and have more information available at the point of reporting. This proposed language was not accepted for legislative sponsorship. Regarding the recommendation, MPI will develop draft contract language to require that MCOs provide additional case information as suggested, including requirements that MCOs provide: an investigative supplementary report at or within 30 days of their required 15-day referral; specifications as to which statutes or rules were violated, a summary of interviews conducted, encounter data submitted by the network provider for the time period in question, and all supporting documentation obtained as a result of the assigned SIU investigation.		

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			Anticipated Completion Date: March 1, 2015		
6	MCOs are not required to provide customized anti-fraud training for specific specialized positions based on the positions' duties and responsibilities.	We recommend MPI develop contract language be expanded requiring MCOs to implement training that is customized to the various positions throughout their organizations. We also recommended that MPI require MCOs to provide training to their personnel on potential fraud risks and the associated "red flags."	**Status as of June 9, 2015:** Completed. MPI has subsequently met with Medicaid staff regarding contract revisions and it was determined that the current contract was satisfactory to require the recommended documentation and activities. **Status as of December 9, 2014:** The Agency concurs with this finding and has already developed related draft contract language. This language was forwarded to the Division of Medicaid with the recommendation for adoption. *Anticipated Completion Date*: March 1, 2015	Completed.	Completed.
7	Few MCOs complied with the statutory requirement to include a summary of investigations for the previous year in the anti-fraud plan. In addition, the reported information varied in the summaries that were provided.	We recommend MPI continue to pursue modifications to Section 409.91212(1)(f), F.S. to read "prior state fiscal year" instead of "previous year." This modification will make it consistent with other subsections of the statute, such as Section 409.91212(4), F.S. This modification will also provide greater clarity to the	**Status as of June 9, 2015:** Completed. See below regarding revisions to the MCO contract "Report Guide." **Status as of December 9, 2014:** The Agency concurs with this finding but believes it has the authority to	Completed.	Completed.

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		MCOs and possibly create greater consistency in the information provided.	effect this change absent a statutory revision. Effective January 1, 2015, the MCO Contract "Report Guide" requires MCOs to report activities from the "prior state fiscal year." This can be found on page 33 of 119 in the Reporting Guide that will become effective January 2015, and reads as follows: *The purpose of this report is to provide the Agency a summarized annual report on the Managed Care Plan's experience in implementing an anti-fraud plan and conducting or contracting for investigations of possible fraudulent or abusive acts for the prior State Fiscal Year (SFY).* *Anticipated Completion Date*: January 1, 2015		
8	MPI does not have written policies and procedures for the review of the anti-fraud plans.	We recommend MPI immediately develop and establish written procedures for the review of the anti-fraud plans that will address the completeness of reviews, timeliness of the reviews, supervisory approval, and documenting correspondence between MPI and the MCOs. This will aid in providing consistency in the review of the anti-fraud plans, continuity when the unit experiences staff turnover, and can be used as a	**Status as of June 9, 2015:** Due to personnel changes, including the hiring of a new Administrator over the Managed Care Unit that was not finalized until after the anticipated completion date of March 1, 2015, the written procedures are scheduled to be completed on or before September 1, 2015. *Anticipated Completion Date:* ***September 1, 2015***.	There have been additional personnel changes in the Managed Care Unit. Specifically, the manager who was preparing the draft Internal Operating Procedure (IOP) left the bureau. A draft, which was completed prior to September 1, 2015, has undergone several revisions. Other priorities have not allowed this document to be finalized. However, it was relied upon in the review of the	January 1, 2016 Ann Kaperak (850) 412-4611

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		training tool. MPI should also further develop the review tool and, at a minimum, include a field for the supervisor's initials and review date. The tool should be considered a central file to document the complete review of the anti-fraud plan including the review of supporting documentation received from the MCO that leads to the approval or disapproval of the submitted anti-fraud plan.	**Status as of December 9, 2014:** The Agency concurs with this finding and has done much to achieve this goal since the initiation of this audit. The Managed Care Unit within MPI has been organized into different groups to address the very specific needs and differences within the various Medicaid managed care plans. The unit is compartmentalized to increase the specific subject matter expertise of each type of managed care plan, and staff has been assigned to specific MCOs. By having continuity of staff evaluating the MCOs' anti-fraud efforts, staff members will be more likely to recognize changes and disparities within the information submitted, thereby raising flags (indicators of deficiencies) or triggers to a real concern within the MCO. As the MCU reviews more anti-fraud plans and find concerns that must be explained by the MCOs, new processes are drafted to specifically address these concerns and maintain consistency in the anti-fraud plan reviews. The MCU has developed a checklist for some required elements of the anti-fraud plans, but some of the flags are actually raised by information omission, the absence of anti-fraud referrals, or are identified	2015 anti-fraud plan submissions. Changes necessitated by lessons learned from the 2015 reviews, lessons learned from other audit processes, and subsequent contract changes that may have impacted the IOP are in process and are expected to be completed by the end of this (2015) calendar year.	

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<tr><th>No.</th><th>Finding</th><th>Recommendation</th><th>Previous Management Response(s)</th><th>Twelve-Month Status Update</th><th>Anticipated Completion Date and Contact</th></tr>
<tr><td></td><td></td><td></td><td>during interaction and communication between the MCOs and MPI.

Anticipated Completion Date: The development of written procedures related to anti-fraud plan reviews and approvals is partially completed. The adoption of Internal Operating Procedures to satisfy the audit recommendations in full are anticipated to be finalized by March 1, 2015.</td><td></td><td></td></tr>
<tr><td>9</td><td>Not all MCU staff members have received external training related to Medicaid fraud prevention, detection, and investigation.</td><td>We recommend that MPI develop a plan to provide MCU staff training on more insurance and public assistance fraud-related topics that will aid them in their review of the anti-fraud plans and conducting field site visits.</td><td><u>Status as of June 9, 2015:</u>
MPI's training processes have been amended. This includes:

(1) The creation of SMART goal requirements for professional development:

Employees will share in the responsibility for their own professional development as well as that of colleagues and coworkers. Professional development includes increasing skills and knowledge to optimize effectiveness within MPI. It includes learning opportunities as an attendee as well as trainer, facilitator, and developer of training.

Rating of 3: On an annual basis, the employee develops (individually or collectively) and presents more than</td><td>Since June 9, 2015, all MPI personnel have had training on Medicaid fraud prevention, detection, and investigation. Training has been both via optional training classes and mandatory training classes. Mandatory training is held at least monthly. Optional training is dependent upon trainer and course availability.

Mandatory classes were held on:

<table><tr><td>11-Jun-15</td><td>Mandatory for specified staff (travel required)</td><td>Fraud and Abuse Issues in Managed Care; Emerging Trends; Prevention and Detection Efforts</td></tr></table></td><td>January 1, 2016

Kelly Bennett
(850) 412-4019</td></tr>
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<td>one substantive topic for MPI staff's overall professional development.

Rating of 4: On an annual basis, the employee develops and presents more than one substantive topic for MPI staff's overall professional development and the employee assists others with the development, facilitation, and presentation of professional development materials.

Rating of 5: In addition to the criteria for a rating of "4," the employee also identifies and attends seminars, workshops, or trainings related to the MPI activities.

(2) Creation of a training program for MPI staff that will afford opportunities to improve competency in key areas. The training program includes internal training classes (e.g. resulting from staff and managers creating relevant trainings), external (commercial and other government agency) trainings, and accreditation/certification attainment. We have created a process to encourage staff to help identify available external trainings and to seek permission to attend. We have requested, through AHCA internal processes, additional funds to meet these needs. The managers are also assisting with updating our</td>
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<table>
<tr><td>11-Sep-15</td><td>Mandatory for specified staff (travel required)</td><td>Fraud and Abuse Issues in Managed Care; Emerging Trends; Prevention and Detection Efforts</td></tr>
<tr><td>16-Sep-15</td><td>Mandatory for all MPI via in person or webinar</td><td>MPI monthly training about fraud, waste and abuse issues in Florida Medicaid</td></tr>
<tr><td>14-Oct-15</td><td>Optional webinar available to all MPI staff</td><td>The Evolving Financial Crime Landscape: Using Next Generation Technologies to Solve the Puzzle</td></tr>
<tr><td>29-Oct-15</td><td>Mandatory for all MPI via in person or webinar</td><td>MPI monthly training about fraud, waste and abuse issues in Florida Medicaid</td></tr>
<tr><td>4-Nov-15</td><td>Optional webinar available to all MPI staff</td><td>Healthcare Fraud Identification of Providers</td></tr>
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Eight core educational components are incorporated into MPI training. Additionally, recent personnel changes as well as further personnel changes (depending on staff and position availability) are anticipated to increase the availability of mandatory and optional training.

Finally, a draft document pertaining to the formalized training program is</td>
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			internal operating procedures. This is a first step to the training seminar development process related to these procedures. (3) Finally, we have developed an assessment process to determine staff with minimum required competencies. Staff are expected to study specified resources and be able to pass a test designed to measure these minimal competencies. We are currently in the process of testing staff to assess their competencies to prioritize training. *Anticipated Completion Date:* ***December 9, 2015****.* **Status as of December 9, 2014:** The Agency concurs that there are ongoing needs for training for staff to keep them apprised of current trends and topics related to their jobs. An overall training program is a priority in MPI and this recommendation will be addressed further through that program. As an immediate measure, MCU has implemented additional cross training and collaboration internally within MPI and within AHCA. Developing a plan to provide sufficient training involves research, up-to-date knowledge on trends, schemes, and	undergoing final review. Further review and staff input is expected to be completed by the end of this (2015) calendar year.	

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			current charges of healthcare-related crimes. The following needs must be considered as this plan is developed: • Identify current and relevant topics; • Identify qualified instructors; • Create a budget for training opportunities; • Identify staff that would most benefit from specific types of training; and • Ensure that compliance resources and outputs will not be compromised by sending staff to training. Sufficient time and resources are needed to bring effective new training and re-training to a large unit. MPI has started this process, and expects to continue the process going forward. *Anticipated Completion Date*: June 1, 2015		
10	MPI does not utilize a risk-based methodology for determining the priority in which the anti-fraud plan reviews are conducted or determining which MCOs are selected for onsite visits.	In identifying best practices, we noted that the State of Texas conducts its audits based on an annual risk-based audit plan. Therefore, we recommend MPI establish a risk based assessment to identify which MCOs require onsite visits. MPI does review certain documents in addition to those needed for the approval or disapproval of the anti-fraud plan. These documents can be used to perform desk reviews to determine if an onsite visit is necessary. We also	**Status as of June 9, 2015:** Due to personnel changes, including the hiring of a new Administrator over the Managed Care Unit that was not finalized until after the anticipated completion date of March 1, 2015, the written procedures are anticipated to be completed on or before September 1, 2015. *Anticipated Completion Date:* ***September 1, 2015***.	There have been additional personnel changes in the Managed Care Unit. Specifically, the manager who was preparing the draft IOP left the bureau. A draft, which was completed prior to September 1, 2015, has undergone several revisions. Other priorities have not allowed this document to be finalized. Furthermore, due to the transition of Medicaid from fee-for-service to managed care, MCO onsite visits	January 1, 2016 Ann Kaperak (850) 412-4611

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		recommend that MPI: • Develop procedures/checklists for desk reviews in addition to the review tool that is currently being used. • Develop a plan of utilizing MPI field office staff to aid MCU in the monitoring of MCOs and conducting onsite visits. • Develop a plan to conduct unannounced onsite visits.	**Status as of December 9, 2014:** The Agency concurs with this finding and has done considerable work to implement these recommendations since this audit was initially engaged. Current and proposed processes do lend themselves to a prioritization methodology for reviewing the anti-fraud plans. All anti-fraud plans are initially reviewed within 30 days of receipt for statutory and contractual compliance. Once a plan has been accepted by MPI, a more thorough review is done. All anti-fraud plans are scrutinized thoroughly, but certain information or circumstances elevate the need for a site visit, a request for more information, or simply to examine a process more in-depth. Examples of some triggers include: • The MCO having their SIU set up in another state; • Little monitoring of the MCO payments and processes by the SIU; • SIU designee sending news clips to the Agency as their indication of anti-fraud monitoring rather than sending specific information regarding MCO-specific situations; • Failure to report 15-day suspicions; • Increase in reporting 30 days prior to the AFARR or QFARR deadline; • Amending previous reports; and • Absence of local staff.	were intentionally deferred by the Agency until 2016. The processes related to anti-fraud plan review IOPs was addressed in number 8, above. Both the IOPs related to anti-fraud plans and MCO monitoring are expected to be completed by the end of this (2015) calendar year.	

Agency for Health Care Administration
Office of the Chief Inspector General
Report Title: Assessment of Managed Care Organizations' Anti-Fraud Plans
Report #: 2014-1, issued December 9, 2014
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No.	Finding	Recommendation	Previous Management Response(s)	Twelve-Month Status Update	Anticipated Completion Date and Contact
			Many of these risk assessment processes are in draft form. Further development of Internal Operating Procedures and processes will be assigned and completed as recommended. *Anticipated Completion Date*: May 1, 2015		