2021

Periodic Audit

Report

Community Care Plan

December 2021

HealthyKids™

Qsource

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List of Tables

Acknowledgements, Acronyms, and Initialisms[1]

AHCA ..... Agency for Health Care Administration
AON ..... Area of Noncompliance
C3..... Concierge Care Coordination
CFR..... *Code of Federal Regulations*
CMS ..... Centers for Medicare & Medicaid Services
CPT ..... Current Procedural Terminology
CY ..... Calendar Year
EQRO..... External Quality Review Organization
FFS ..... Fee-for-Service
FHKC ..... Florida Healthy Kids Corporation
HCPCS..... Healthcare Common Procedure Coding System
HHS..... Department of Health and Human Services
ICD ..... International Classification of Diseases
ID..... Identification
LEIE ..... List of Excluded Individuals and Entities
MCO..... Managed Care Organization
MSC ..... Medical Services Contract

[1] *Other company and product names may be trademarks of the respective companies with which they are associated. The mention of such companies and product names is with due recognition and without intent to misappropriate such names or marks.*

NCCI ..... National Correct Coding Initiative
NDC ..... National Drug Code
NPI ..... National Provider Identifier
OIG..... Office of Inspector General
P&P ..... Policy and Procedure
PAHP ..... Prepaid Ambulatory Health Plan
PCP..... Primary Care Provider
PDL ..... Preferred Drug List
PDNA ..... Provider Denials of Payments for New Admissions
PIHP..... Prepaid Inpatient Health Plan
PML..... Provider Master List
Qsource® ..... a registered trademark
SAM ..... System for Award Management
SIU ..... Special Investigations Unit
SOP..... Standard Operating Procedure
SQL..... Structured Query Language

Executive Summary

Background

Pursuant to Title 42 of the *Code of Federal Regulations*, Section 438.602(e) [42 CFR § 438.602(e)], as incorporated by 42 CFR § 457.1285, Florida Healthy Kids Corporation (FHKC) "must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP."

FHKC contracted with Qsource, an external quality review organization (EQRO), to conduct this 2021 Periodic Audit to audit the accuracy, truthfulness, and completeness of data submitted by the managed care organizations (MCOs) in calendar year (CY) 2020. This *2021 Periodic Audit Report* presents findings from an audit of claims and encounters adjudicated by Community Care Plan (hereafter referred to as Community Care) in CY 2020 and an assessment of compliance with federal and contractual program integrity requirements.

Methodology

Qsource obtained monthly eligibility data for Florida Healthy Kids enrollees for CY 2020 from FHKC's enrollment broker. Quarterly claim and encounter data adjudicated in CY 2020 were submitted by the MCO. In addition, Community Care provided detailed provider data, including all providers for whom claims or encounters were adjudicated in CY 2020 and preferred drug lists (PDLs) in effect in CY 2020.

Qsource compiled, integrated, and analyzed these data to establish the completeness and accuracy of claim and encounter data submitted by Community Care:

- Completeness and Accuracy of Key Data Fields Submitted
  - Claims
  - Encounters
  - Pharmacy
- Validation of Encounter Samples through Medical Record Review
- Accuracy of Benefit Application
  - Duplicated Payments
  - Eligibility on Date of Service
  - Benefit Scope and Benefit Limitations
  - Service Limitations
  - Service Copays

Based on the Centers for Medicare & Medicaid Services (CMS) *Protocol 5: Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan* (2019) recommendation regarding acceptable rates of accuracy and completeness, a targeted error rate below 5% was applied for completeness and accuracy analysis.

For truthfulness of data submitted, Qsource conducted a comprehensive assessment of the MCO's compliance with federal (42 CFR § 438.608, as incorporated by 42 CFR § 457.1285) and contractual (Medical Services Contract) program integrity requirements and evidence of adequate program integrity processes in operational practice during CY 2020. To facilitate comparison across MCOs, the level of the MCO's compliance with program integrity requirements was determined according to criteria based on relative strengths and weaknesses and the extent to which they impacted the MCO's compliance with program integrity requirements.

Results, Conclusions, and Recommendations

Results

Results of the 2021 Periodic Audit demonstrated that Community Care's key claim data fields were highly complete and accurate, all exceeding 97.4%. Completeness and accuracy rates for all key encounter data fields were over 99.9%. Completeness rates for key pharmacy data fields were over 99.3%, with the exception of Treating Provider Type, Treating Provider Medicaid Identification (ID), and Treating Provider Specialty Code, all at 81.8%. Accuracy rates for all key pharmacy data fields were 99.8% or higher.

For accuracy of benefit application, the number of duplicate claims and encounters submitted was minimal (676) when compared to total claims and encounters submitted. The vast majority of the duplicate claims were coded with a zero amount paid, suggesting they may actually have been denied. Removing these claims from the analysis, only 7 duplicate claims appeared to have been

paid, resulting in a potential error rate of 1.0%. All duplicates coded as paid represented only 0.5% of total claims and encounters.

For eligibility of the enrollee on the date of service, very few claims for services when the enrollee was not eligible were submitted (376). The majority of the claims had a header claim line status of paid, resulting in a potential error rate of 87.0%. These paid claims accounted for a negligible percentage of total claims submitted (0.2%).

For services within benefit scope and benefit limitations paid, of the 16 applicable service categories for which benefits would typically be paid, 5 service categories (31.3%) demonstrated potential error rates over the acceptable 5% rate. For 7 categories, less than 100 services were reported and were not included in analyses. A factor that may have impacted potential error rates was the appropriate denial of services based on utilization review, which was not considered in this analysis. Denied claims/encounters for these services were negligible in comparison to total claims and encounters, below 1.0% for all categories except Primary Care Provider (PCP) Routine Vision Screening (1.1%) and PCP Routine Hearing Screening (2.1%).

For services over benefit limitations, the potential error rate (0.75%) for Prescription Drugs was within standard. The remaining seven categories had less than 100 services reported and were not included in analyses.

For services with applicable copays, the potential error rate exceeded the acceptable 5% rate across all service categories, ranging from 8.5% to 100%. The one exception was PCP Visits, for which analysis was not applicable as Community Care waives all PCP visit copays as an additional enrollee benefit. In the majority of cases, appropriate copays applicable to specific services were not identified in the patient responsibility amount field in the data submission.

The truthfulness assessment was based on an evaluation of compliance with program integrity regulatory and contractual requirements. Community Care's overall score on the program integrity standard was 84.7%. For this assessment, two strengths were identified related to Community Care's compliance training program and comprehensive policies and procedures (P&Ps). Two suggestions were noted, related to documenting and maintaining adequate Special Investigations Unit (SIU) staffing and resources and reporting recoveries of overpayments to FHKC. Five areas of noncompliance (AONs) were identified, two related to documenting contract requirements, and the remaining three related to documentation of suspension of payments to providers, prohibited affiliations, and provider reporting of overpayments.

Conclusions

Based on analyses, Qsource concludes that Community Care's data submission for key claim and encounter data fields enabled a confident determination that the data for these fields were highly complete and accurate. However, key pharmacy claim data fields were less complete but were

highly accurate. Aberrations in data submitted by Community Care resulted in less confidence in determinations of accurate claim/encounter payments and potential error rates for duplicated payments, eligibility on date of service, benefit scope and benefit limitations, service limitations, and services with applicable copays. However, potential errors in claim/encounter processing accuracy accounted for a negligible percentage of total claims submitted. For the truthfulness assessment, Qsource concludes that Community Care reflected requirements in operational practice but updates are needed to ensure appropriate documentation of requirements.

Recommendations

Qsource recommends that the MCO audit a sample of claim/encounter detail for services for which the potential error rate was above the acceptable rate of 5% to attempt to determine the cause of the results. Qsource also recommends that Community Care address the suggestions and AONs identified in the program integrity analysis by updating appropriate documentation. Last, Qsource suggests FHKC consider providing additional clarification on appropriate coding for capitation and sub-capitation arrangements and the versioning methodology for adjustments to ensure consistency in reporting among MCOs.

Background

As administrator of the Florida Healthy Kids program, FHKC contracted with Qsource to perform federally required activities, including this Periodic Audit. Qsource meets the federal qualifications for EQROs set forth in 42 CFR § 438.354. Qsource conducted the Periodic Audit per 42 CFR § 438.602(e), as incorporated by 42 CFR § 457.1285, which requires that FHKC periodically conduct, or contract for the conduct of, an independent audit of encounter and financial data accuracy, truthfulness, and completeness for each MCO. The Periodic Audit must be conducted at least every three years.

For this audit, Qsource assessed the accuracy and completeness of claim and encounter data adjudicated by the MCO in CY 2020. Truthfulness of data was assessed through an audit of how the MCO complies with federal and contractual standards for program integrity, along with a detailed analysis of how program integrity requirements were implemented in operational practice in CY 2020.

Methodology

Completeness and Accuracy of Claim and Encounter Data

Qsource obtained monthly eligibility data for CY 2020 from the FHKC enrollment broker. Claim and encounter data adjudicated in CY 2020 were provided quarterly by the MCO in the standard FHKC claim/encounter data layout, as included in Appendix A. Community Care was provided specific instructions on how to report claim and encounter data in the prescribed format, including the use of versioning to consistently report adjustments. Qsource also secured detailed provider

data from the MCO, including all participating and nonparticipating providers for whom claims and encounters were adjudicated in CY 2020. Last, to assess accuracy of pharmacy claim processing, Qsource also secured PDLs for the MCO effective during CY 2020.

Qsource used SQL [Structured Query Language] Server Management Studio to manage claim and encounter data and determine frequencies and rates in health services data on specific fields or variables created explicitly for data validation to indicate potential concerns.

Completeness and Accuracy of Key Data Fields

Analyzing MCO-submitted claim and encounter data, Qsource conducted basic integrity checks to determine if key data existed, if they met expectations, and if they were of sufficient quality. Having no data present in one of these fields counted as an incomplete record. Within completed fields, Qsource examined data for accuracy as determined by specified accuracy checks described below. Accuracy checks reveal overall data quality issues, such as an inability to process or retain certain fields, coding limitations, or data submission issues. Qsource applied completeness and accuracy checks to claim, encounter, and pharmacy data separately, verifying that key data fields contained non-missing values in the correct format and specificity, within required ranges. In addition, Qsource applied a targeted error rate below 5% for completeness and accuracy analysis, based on CMS EQR Protocol 5.

The validation techniques employed for analyses addressed field-specific questions:

1. Are the data available? All required data elements should be reported, and data should exist for all service types with no gaps.
2. Are the data of the type requested? Data should be of the correct type and size in relation to the data dictionary; e.g., Current Procedural Terminology, 4th Edition (CPT-4) procedure codes should have five digits.
3. Compared to an external standard, are the values in the field valid and in the correct format? Values in the diagnosis field, for example, should use current and valid International Classification of Diseases (ICD-10) diagnosis codes.
4. Are FHKC's enrollee identifications (IDs) accurately incorporated into the MCO's information system?

Validation of Encounter Data through Medical Record Review

CMS Protocol 5 defines encounter data as "the information related to the receipt of any item or service by a beneficiary enrolled in a managed care plan … regardless of if or how the [MCO] ultimately reimbursed the provider. Providers submit claims or encounters to [MCOs] for service(s) rendered that would traditionally be submitted as claims in a FFS [fee-for-service] system." Encounter data are typically the detailed service data for providers whose services are covered under a capitation financial arrangement (i.e., per enrollee per month payments) and, therefore, are not billed as individual claims to MCOs. Validation determines the completeness and accuracy of

encounter data to inform policy and operational decision-making, assess quality, monitor program integrity, and determine capitation payment rates.

Qsource selected a statistically valid stratified random sample of statewide physician encounters for service dates from January 1, 2020, through March 31, 2020, from two of the MCOs (Aetna Better Health of Florida and Simply Healthcare Plans, Inc.) serving the Florida Healthy Kids population. Community Care, the third MCO, did not report any physician encounters in CY 2020 and thus was not included in the medical record review.

Accuracy of Benefit Application

The premise of this analysis holds that if the MCO accurately and completely reports claim and encounter data in the format required and according to instructions provided, accuracy of benefit application can be approximated through integration and analysis of the data files. For the accuracy of benefit application analysis, Qsource assessed the following:

- Duplicated Payments – Qsource analyzed claims data to determine the extent to which any duplicates of prior payments were paid.
- Eligibility on Date of Service – Qsource used monthly eligibility files to identify services for which enrollees were ineligible due to non-enrollment. Results were determined based on the number of services paid for which the enrollee was not eligible for benefits at the time of service.
- Benefit Scope and Benefit Limitations – Using the benefit plan for the Florida Healthy Kids program, Qsource analyzed select benefits (those that can be accurately analyzed for one calendar year of claims and encounters) for services not paid that were within the benefit scope and benefit limitations. Results were based on the number of services within the benefit scope not paid versus the total number of services reported.
- Service Limitations – Using defined benefit limitations, Qsource analyzed select benefits (those that can be accurately analyzed for one calendar year of claims and encounters) for services over limitations that were paid. Results were based on the total services over limitations that were paid versus the total services exceeding the limitation threshold.
- Service Copays – Qsource used the defined cost-sharing requirements by benefit type to determine the extent to which appropriate cost-sharing was applied. Results were based on total services for which cost-sharing was applied versus total services reported for which copays were applicable.

The analysis of benefit application is based on the assumption that the MCO adhered to specific data submission guidelines and instructions when submitting claim and encounter data. However, aberrations in MCO data submission may have resulted in differences between results included in this report based on MCO-provided data and actual adjudication results. Due to possible deviations

in the MCO's data submission, results should be interpreted with caution. As a result, Qsource has identified for each analysis category the potential error rate rather than a definitive error rate.

Truthfulness of Claim and Encounter Data

Qsource conducted an analysis of program integrity to establish a level of truthfulness of claim and encounter data provided by the MCO. For this assessment, Qsource reviewed documentation submitted by Community Care to demonstrate compliance with federal requirements as codified in 42 CFR § 438.608 and incorporated by 42 CFR § 457.1285, and contractual program integrity requirements as set out in the Medical Services Contract with FHKC. In addition, Qsource conducted a virtual review, interviewing key MCO staff relative to program integrity standards to facilitate analyses and compilation of findings. The documentation review and virtual review findings were documented in a Program Integrity standard tool, developed to assess compliance with each relevant CFR and Medical Services Contract provision related to the Program Integrity standard. The tool included each requirement as a standard element, each of which was evaluated as Met or Not Met. Qsource identified strengths, AONs, and suggestions that would strengthen compliance where applicable. Each element was assigned a compliance score, and an overall percentage score was calculated for the entire Program Integrity standard based on the number of elements compliant out of all elements assessed. This score was used to determine the MCO's level of Program Integrity compliance, as shown in **Table 1**. Detailed results of the documentation and virtual reviews for Community Care are included in the completed Program Integrity tool in Appendix B.

Table 1. Program Integrity Compliance Criteria

Level of Compliance	Criteria
High	90–100% compliance score for program integrity review
Moderate	80–89.9% compliance score for program integrity review
Low	70–79.9% compliance score for program integrity review

Qsource also requested evidence of program integrity processes applied in operational practice in CY 2020. The following documentation was obtained from the MCO and reviewed by Qsource:

1. Prospective claims system edits to prevent fraud, waste, and abuse
    a. List of edits
        i. National Correct Coding Initiative (NCCI) edits (evidence of quarterly integration in claims system)
        ii. Other prospective edits
2. Retrospective processes for screening claims data for fraud, waste, and abuse
    a. Standard reporting and screening processes
    b. Specific investigation processes
    c. Sample screening reports

3. Follow-up on identified fraud, waste, and abuse processes
    a. Standard follow-up processes
    b. Sample report of follow-up activity results
4. Processes for flagging federally and state excluded providers for nonpayment

Results

Completeness and Accuracy of Key Data Fields

For this section's results, the acceptable error rate is considered to be 5%, so any completeness or accuracy rate less than 95% is presented in bold red text. **Table 2** displays completeness and accuracy rates for key claim data fields for Community Care.

Table 2. Completeness and Accuracy Rates—Claim Lines Submitted by Community Care

Field	Present	Completeness Rate	Accurate	Accuracy Rate*
	N=272,608			
Member Identification (ID)	272,608	100%	272,608	100%
Plan ID	272,608	100%	272,608	100%
Claim Reference Number	272,608	100%	272,608	100%
Billing Date	272,608	100%	272,608	100%
Claim Paid Date	272,608	100%	272,608	100%
Admit Date†	23,317	100%	23,317	100%
Diagnosis Code	272,592	99.99%	271,468	99.59%
Procedure Code	266,900	97.91%	265,282	99.39%
First Date of Service	272,608	100%	272,608	100%
Last Date of Service	272,608	100%	272,608	100%
Units of Service	272,608	100%	272,608	100%
Total Days	272,608	100%	272,608	100%
Financial Report Service Category	272,608	100%	272,608	100%
Treating Provider Type	272,608	100%	272,608	100%
Treating Provider National Provider Identifier (NPI)	272,466	99.95%	272,466	100%
Treating Provider Medicaid ID	270,963	99.40%	270,957	100%**
Treating Provider Specialty Code	272,608	100%	272,052	99.80%
Billing Provider Type	272,608	100%	272,608	100%
Billing Provider NPI	272,608	100%	272,608	100%
Billing Provider Medicaid ID	272,266	99.87%	272,266	100%

Table 2. Completeness and Accuracy Rates—Claim Lines Submitted by Community Care				
Field	**Present**	**Completeness Rate**	**Accurate**	**Accuracy Rate***
Billing Provider Specialty Code	272,608	100%	272,567	99.98%
Facility Provider Type†	23,300	99.93%	23,300	100%
Facility Provider NPI†	23,317	100%	23,317	100%
Facility Provider Medicaid ID†	23,299	99.92%	23,299	100%
Place of Service††	249,291	100%	242,978	97.47%

** Accuracy rates are those deemed accurate of records determined complete.*
† Applicable to institutional claims only
*** This figure was rounded to 100%.*
†† Applicable to professional claims only

Completeness rates for all key claim data fields were over 97.9% and accuracy rates were over 97.4%.

Table 3 displays completeness and accuracy rates for key encounter data fields for Community Care.

Table 3. Completeness and Accuracy Rates—Encounter Lines Submitted by Community Care				
Field	**Present**	**Completeness Rate**	**Accurate**	**Accuracy Rate***
N=10,761				
Member Identification (ID)	10,761	100%	10,761	100%
Plan ID	10,761	100%	10,761	100%
Claim Reference Number	10,761	100%	10,761	100%
Billing Date	10,761	100%	10,761	100%
Claim Paid Date	10,761	100%	10,761	100%
Diagnosis Code	10,761	100%	10,761	100%
Procedure Code	10,760	100%†	10,755	99.95%
First Date of Service	10,761	100%	10,761	100%
Last Date of Service	10,761	100%	10,761	100%
Units of Service	10,761	100%	10,761	100%
Total Days	10,761	100%	10,761	100%
Financial Report Service Category	10,761	100%	10,761	100%
Treating Provider Type	10,761	100%	10,761	100%
Treating Provider National Provider Identifier (NPI)	10,753	99.93%	10,753	100%
Treating Provider Medicaid ID	10,753	99.93%	10,753	100%

Table 3. Completeness and Accuracy Rates—Encounter Lines Submitted by Community Care				
Field	**Present**	**Completeness Rate**	**Accurate**	**Accuracy Rate***
Treating Provider Specialty Code	10,761	100%	10,761	100%
Billing Provider Type	10,761	100%	10,761	100%
Billing Provider NPI	10,761	100%	10,761	100%
Billing Provider Medicaid ID	10,761	100%	10,761	100%
Billing Provider Specialty Code	10,761	100%	10,761	100%
Place of Service†	10,095	100%	10,095	100%

** Accuracy rates are those deemed accurate of records determined complete.*
† This figure was rounded to 100%.

Completeness and accuracy rates for all key encounter data fields were over 99.9%.

Table 4 displays completeness and accuracy rates for key pharmacy data fields for Community Care.

Table 4. Completeness and Accuracy Rates—Pharmacy Lines Submitted by Community Care				
Field	**Present**	**Completeness Rate**	**Accurate**	**Accuracy Rate***
N=82,792				
Member Identification (ID)	82,792	100%	82,792	100%
Plan ID	82,792	100%	82,792	100%
Claim Reference Number	82,792	100%	82,792	100%
Billing Date	82,792	100%	82,792	100%
Claim Paid Date	82,792	100%	82,792	100%
First Date of Service	82,792	100%	82,792	100%
Units of Service	82,792	100%	82,792	100%
Financial Report Service Category	82,792	100%	82,792	100%
Treating Provider Type	67,689	**81.76%**	67,689	100%
Treating Provider National Provider Identifier (NPI)	82,792	100%	82,792	100%
Treating Provider Medicaid ID	67,689	**81.76%**	67,689	100%
Treating Provider Specialty Code	67,689	**81.76%**	67,689	100%
Billing Provider Type	82,233	99.32%	82,233	100%
Billing Provider NPI	82,792	100%	82,792	100%
Billing Provider Medicaid ID	82,250	99.35%	82,250	100%
Billing Provider Specialty Code	82,233	99.32%	82,233	100%
National Drug Code (NDC)	82,659	99.84%	82,659	100%
Class	82,792	100%	82,629	99.80%

Table 4. Completeness and Accuracy Rates—Pharmacy Lines Submitted by Community Care				
Field	**Present**	**Completeness Rate**	**Accurate**	**Accuracy Rate***
Primary Pharmacy ID	82,792	100%	82,792	100%
Days' Supply	82,792	100%	82,792	100%

** Accuracy rates are those deemed accurate of records determined complete.*

Completeness rates for key pharmacy data fields were over 99.3%, with the exception of Treating Provider Type, Treating Provider Medicaid ID, and Treating Provider Specialty Code, all at 81.8%. Accuracy rates for all key pharmacy data fields were 99.8% or higher.

Accuracy of Benefit Application

As noted in the methodology description, the error rate for results of the accuracy of benefit application analysis is not definitive due to possible aberrations in MCO data submission that may have caused the results included in this report to be different than the MCO's actual adjudication results. The potential error rate rationale applies to **tables 5**, 6, 7, 8, and 9. The acceptable potential error rate is considered to be 5%, so any potential error rate above 5% is presented in bold red text.

Table 5 displays total duplicate claims and encounters reported, total duplicate claims and encounters paid, potential error rate, and paid duplicates as a percentage of total claims and encounters for Community Care, where the potential error rate indicates the percentage of duplicate claims and encounters reported that were paid according to the data submitted by the MCO.

Table 5. Duplicated Payment	
Duplicate Claims/Encounters Reported	676
Total Duplicate Claims/Encounters Paid	641
Potential Error Rate	**94.82%**
Paid Duplicates as % of Total Claims/Encounters	**0.48%**

A relatively small number of duplicate claims and encounters were identified (676) with the majority of these indicated as paid. This resulted in a very high potential error rate of 94.8%. However, detailed analysis demonstrated that 634 of these were actually claims/encounters with a header claim line status of paid ("P") with a zero amount paid, indicating these claims/encounters may actually have been denied. Removing these from the analysis, only 7 duplicate claims/encounters were coded as paid, reducing the potential error rate to 1.0%. All duplicate claims and encounters coded as paid accounted for a negligible percentage of total claims and encounters submitted (0.5%).

Table 6 displays services for which enrollees were not eligible on the date of service, total number of these services paid, potential error rate, and ineligible services paid as a percentage of total claims and encounters for Community Care.

Table 6. Eligibility on Date of Service	
Total Services for Which Enrollee Not Eligible on Date of Service	376
Ineligible Services Paid	327
Potential Error Rate	**86.97%**
Paid Ineligible Services as % of Total Claims/Encounters	**0.24%**

Eligibility on the date of service was established by linking enrollee ID numbers in monthly enrollment files to dates of service in claim and encounter data submitted. Services were validated as eligible for coverage based on the service date on the claim or encounter and the presence of an enrollment record for the associated month of service. Only 376 claims/encounters were submitted for ineligible dates of service. Of these, 327 had a paid status. This resulted in a high potential error rate, 87.0%. However, these claims/encounters were insignificant when compared to total claims/encounters submitted, representing only 0.2%.

Table 7 displays total services within the Florida Healthy Kids benefit scope, total number of these services reported as not paid, potential error rate, and services within benefit scope and benefit limitations that were not paid as a percentage of total claims and encounters for Community Care. Due to the potential for misleading percentages as a result of small numbers, service categories with less than 100 services reported were excluded from the analyses.

Table 7. Services within Benefit Scope and Benefit Limitations by Service Category

Service Category	Services Within Benefit Scope and Benefit Limitations Reported*	Services Within Benefit Scope and Benefit Limitations Not Paid	Potential Error Rate	Services Within Benefit Scope and Benefit Limitations Not Paid as % of Total Claims/ Encounters
Primary Care Provider (PCP) Office Visit	17,516	49	0.28%	**0.04%**
PCP Well-Child Care	890	1	0.11%	**0%**
PCP Immunizations	7,707	1,074	**13.94%**	**0.80%**
PCP Routine Vision Screening	1,583	1,515	**95.70%**	**1.13%**
PCP Routine Hearing Screening	3,784	2,789	**73.71%**	**2.08%**
Specialist Office Visit	16,615	56	0.34%	**0.04%**
Chiropractor	121	0	0%	**0%**

Table 7. Services within Benefit Scope and Benefit Limitations by Service Category				
Service Category	**Services Within Benefit Scope and Benefit Limitations Reported***	**Services Within Benefit Scope and Benefit Limitations Not Paid**	**Potential Error Rate**	**Services Within Benefit Scope and Benefit Limitations Not Paid as % of Total Claims/ Encounters**
Podiatrist	4267	578	**13.55%**	**0.43%**
Diagnostic Testing	17,643	10	0.06%	**0.01%**
Outpatient Behavioral Health and Substance Abuse Treatment	1,705	0	0%	**0%**
Inpatient Services (including behavioral health and substance abuse services)	1,380	1	0.07%	**0%**
Inpatient Hospital or Nursing Facility for Rehabilitation or Physical Therapy	†	†	†	†
Maternity Care – Mother	†	†	†	†
Family Planning Visit	†	†	†	†
Emergency Room	5,017	3	0.06%	**0%**
Emergency Transportation	†	†	†	†
Urgent Care Center	1,921	0	0%	**0%**
Home Health	†	†	†	†
Hospice	†	†	†	†
Refraction – Optometrist	905	0	0%	**0%**
Corrective Lenses and Frames	379	0	0%	**0%**
Durable Medical Equipment	275	40	**14.55%**	**0.03%**
Nursing Facility	†	†	†	†

** Eligible services are covered services within any benefit limitation.*
† Less than 100 services within benefit scope and benefit limitations reported

For 7 of the 23 service categories, less than 100 services were reported and were not included in the analysis. Across the 16 remaining service categories, approximately 92.5% of services within benefit scope and limitations were reported as paid (75,592 out of 87,708 total services). For five of these categories, the potential error rate exceeded the 5% standard: Primary Care Provider (PCP) Immunizations, 13.9%; PCP Routine Vision Screening, 95.7%; PCP Routine Hearing Screening, 73.7%; Podiatrist, 13.6%; and Durable Medical Equipment, 14.6%. Potential error rates among remaining categories were less than 0.4%. A factor that may have impacted potential error rates was the appropriate denial of services based on utilization review, which was not considered in

this analysis. The percentage of total claims and encounters ranged from 0% to 2.1% for all five categories. For the remaining service categories, the percentage of total claims and encounters was less than 0.8%.

Table 8 displays total services over limitation reported, total services over limitation that were reported as paid, potential error rate, and services over limitation that were paid as a percentage of total claims and encounters for each category for Community Care. Due to the potential for misleading percentages as a result of small numbers, service categories with less than 100 services reported were excluded from the analyses.

Table 8. Services Over Limitation by Service Category

Service Category	Services Over Limitation Reported	Services Over Limitation Paid	Potential Error Rate	Services Over Limitation Paid as % of Total Claims/ Encounters
Prescription Drugs – 31 Days' Supply, January – March; 90 Days' Supply, April – December*	1,199	9	0.75%	**0.01%**
Inpatient Stays for Rehabilitation and Physical Therapy – 15 Days per Calendar Year	†	†	†	†
Chiropractic Services – One Visit per Day	†	†	†	†
Chiropractic Services – 24 Visits per Calendar Year	†	†	†	†
Podiatric Services – One Visit per Day	†	†	†	†
Podiatric Services – Two Visits per Month	†	†	†	†
Family Planning Services – One Visit Every 90 Calendar Days	†	†	†	†
Nursing Facility (except stays for rehabilitation and physical therapy) – 100 Days per Calendar Year	†	†	†	†

** COVID-19 relief efforts extended days' supply limit to 90 days from April through December 2020.*
† Less than 100 services over limitation reported

For most all benefit categories, the number of services reported over benefit limitations was low (less than 100). The exception was Prescription Drugs, for which the potential error rate was well within the acceptable 5% standard.

Table 9 displays total services for which copays applied, total of those services for which copays were not applied, potential error rate, and services for which copays were not applied as a percentage of total claims and encounters in each category. Due to the potential for misleading

percentages as a result of small numbers, service categories with less than 100 services reported were excluded from the analyses.

Table 9. Services for Which Copays Applied by Service Category

Service Category	Total Services for Which Copays Applied Reported	Services for Which Copays Not Applied	Potential Error Rate	Services for Which Copays Not Applied as % of Total Claims/ Encounters
Prescription Drugs – $5 per Prescription	12,096	4,261	**35.23%**	**NA**
Primary Care Provider Visits*/** (excluding well-child care, preventive visits, immunizations, routine hearing and vision screening) – $5 per Visit	Not Applicable	Not Applicable	Not Applicable	**Not Applicable**
Specialist Office Visits – $5 per Visit	8,468	7,371	**87.05%**	**5.51%**
Chiropractic Visits – $5 per Visit	100	12	**12.00%**	**0.01%**
Podiatric Visits – $5 per Visit	178	27	**15.17%**	**0.02%**
Emergency Room Services** – $10 per Visit, Waived if Admitted	141	12	**8.51%**	**0.01%**
Vision Services – $5 per Visit	898	898	**100%**	**0.67%**
Corrective Lenses – $10 per Item	379	379	**100%**	**0.28%**
Behavioral Health/Substance Abuse Disorder Specialist Visits** – $5 per Visit	288	288	**100%**	**0.22%**
Physical Therapy – $5 per Visit	1,547	1,520	**98.25%**	**1.14%**
Occupational Therapy – $5 per Visit	1,547	1,479	**95.60%**	**1.10%**
Respiratory Therapy – $5 per Visit	155	135	**87.10%**	**0.10%**
Speech Therapy – $5 per Visit	1,066	1,065	**99.91%**	**0.80%**

** Community Care waives the PCP visit copay as an additional enrollee benefit.*
*** COVID-19 relief efforts waived applicable copays from April through December 2020.*

Across all service categories, the potential error rate exceeded the 5% standard, resulting from the lack of accurate population of the patient responsibility amount field in the data submission. For most of these categories, inaccurate copays as a percentage of total claims and encounters were negligible (less than 1.0%). However, the percentage exceeded 1.0% of total claims/encounters for Specialist Office Visits (5.5%), Physical Therapy (1.1%), and Occupational Therapy (1.1%).

Summary of Data Submission Issues Observed

In completing this analysis, a significant number of fee-for-service claims coded as paid with a negative or zero amount paid were identified.

Truthfulness of Claim and Encounter Data

During the review, Qsource surveyors used the tool in Appendix B—along with personal observations, interviews with MCO staff, and system demonstrations—to facilitate analyses and compilation of findings. The results include identified performance strengths, suggestions, and AONs (**Table 11**).

Table 10 includes Community Care's performance on the Program Integrity standard tool (review of regulatory and contractual compliance) as detailed in Appendix B. A score of 100% on an element indicates that the MCO fully met the criteria and, therefore, is in full compliance.

Table 10. 2020 Program Integrity Compliance Standard Score	
Community Care	84.7%

Community Care's documentation was compliant for all but seven criteria from all 12 elements in the evaluation tool, resulting in an overall score of 84.7%.

Strengths, Suggestions, and Areas of Noncompliance (AONs)

Strengths indicate that the MCO demonstrated particular proficiency on a given element and can be identified regardless of compliance score; the lack of an identified strength should not be interpreted as a shortcoming on the part of the MCO. Suggestions are recommendations that are not required to meet compliance, but include possible improvements to policies and procedures (P&Ps) or processes for the MCO to consider regardless of score. AONs are identified where the MCO achieved less than 100% compliance and reflect what the MCO should do to improve performance.

Table 11 summarizes the strengths, suggestions, and AONs for Community Care.

Table 11. Strengths, Suggestions, and Areas of Noncompliance	
Strengths	
Element 1: Fraud, Waste, and Abuse Procedure Components – 1	1. Policy #CO14003 provided a detailed description of the compliance training program for employees. 2. The managed care organization (MCO) maintained comprehensive compliance policies and procedures.
Suggestions	
Element 6: Fraud, Waste, and Abuse Procedure Components – 6	The MCO could update the Compliance Plan or the SIU [Special Investigations Unit] Antifraud Plan to specifically address maintaining adequate SIU staffing and resources for investigations and corrective action plan development.
Element 10: Treatment of Recoveries	The MCO could update Policy #CP14029 to include reporting recoveries and overpayments to Florida Healthy Kids Corporation (FHKC).

Table 11. Strengths, Suggestions, and Areas of Noncompliance	
AONs	
Element 1: Fraud, Waste, and Abuse Procedure Components – 1	1. The MCO should update the Compliance Plan to include that written policies and procedures address standards under the contract. 2. The MCO should update the Compliance Plan to address the Compliance Committee responsibility to ensure compliance with requirements under the contract.
Element 4: Fraud, Waste, and Abuse Procedure Components – 4	The MCO should update Policy #CO14017 to include suspension of payments to providers for which FHKC has identified a credible allegation of fraud.
Element 9: Disclosures	The MCO should document the written disclosure of prohibited affiliations in the Compliance Plan.
Element 10: Treatment of Recoveries	The MCO should update the provider manual or Master Services Agreement to address mechanisms for providers to report and refund overpayments to the MCO within 60 calendar days of identification and include the reason for the overpayment.

Two strengths were identified for Community Care: the detailed description of the compliance training program for employees, and comprehensive compliance P&Ps. Five AONs were identified, two of which related to specifically addressing FHKC contract provisions in the MCO's compliance documentation. The remaining three related to documentation of written disclosures of prohibited affiliations, suspension of payments processes, and requiring providers to report overpayments and the reason for the overpayment to the MCO within 60 calendar days of identification. While Community Care demonstrated compliance in operational practice, a suggestion was made to document reporting recoveries and overpayments to FHKC. Last, a suggestion was made to address maintaining adequate Special Investigations Unit (SIU) staffing and resources as required by the FHKC contract.

Further assessment of program integrity processes in the MCO's operational practice is presented in **tables 12**, 13, 14, and 15.

Table 12. Prospective Claim System Edits	
National Correct Coding Initiative (NCCI)	Policy #CL015: Virtual Examiner referenced NCCI edits for Healthcare Common Procedure Coding System (HCPCS) produced by the Virtual Examiner reporting system, which was used to identify age, gender, and place of service related coding errors.
Other	Virtual Examiner RSN Messages User Manual, Appendix E described detailed prospective edits in four categories integrated in the claims system.

Community Care provided documentation of comprehensive prospective claim system edits, including required NCCI edits, and other edits to identify potential fraud, waste, and abuse and accurately process claim data.

Table 13. Retrospective Processes for Claim Screening	
Standard Reporting and Screening Processes	Policy #CO14035: Special Investigation Unit (SIU) Claims Auditing Sampling Process and Procedure outlined the process and methodology used to sample claims for SIU auditing related to coding and billing issues; identified overpayments; and suspected fraud, waste, and abuse.
Specific Investigation Processes	Policy #CO14035 indicated that after a detailed claims report was generated for the scenario and appropriate time frame, medical records were requested either for all claims identified or for a sample size of 15% of the claims identified in the scenario. Should any adverse findings be identified in the standard sample, the audit scope would expand to a larger volume as determined by the SIU. The SIU reviewed the appropriateness of claims billed by the provider and ensured accuracy of payment. The SIU reviewed and validated services against coverage, limitations, and exclusion guidelines. The SIU used the most current accepted coding systems and considered federal, state, Centers for Medicare & Medicaid Services regulatory, and contract requirements; American Medical Association guidelines; and generally accepted coding practices. Written clinical documentation of services was verified and validated against claims. The review resulted in identification of coding errors, inconsistencies, anomalies, abnormal billing patterns, and other indicators (e.g., services not rendered, upcoding, unbundling) of suspected fraud and abuse.
Sample Screening Reports	A sample detailed retrospective claim screening template was provided.

Community Care provided documentation of standard reporting and screening processes for identifying potential fraud, waste, and abuse, including samples of detailed claims screening reports.

Table 14. Follow-Up Processes	
Standard Follow-Up Processes	Policy #CO12014: Fraud, Waste and Abuse and Overpayment Investigation Process outlined follow-up activities after investigations were complete, including review of evidence and detailed findings in a final summary report for comprehensive understanding of the facts, actions to be taken, and follow-up if needed. When findings were identified, an education letter might be produced and follow-up completed to ensure compliance in the future. For recurrence, the Special Investigations Unit would take appropriate action under a new case.
Sample Follow-Up Activities Conducted	An Audit Report Summary template included detailed results of a provider audit, including the audit objective, scope, results, action required, and appeal rights.

Community Care provided documentation of appropriate follow-up processes and activities based on identification of questionable billing practices.

Table 15. Claims System Flagging for Nonpayment	
Federal and State Excluded Providers	Policy #CO14030: Exclusion Database Screening and AHCA [Agency for Health Care Administration] Ineligible Providers included a detailed process by which state and federally excluded providers were marked ineligible in the system.

Community Care provided appropriate documentation of flagging of excluded providers for nonpayment.

Conclusions and Recommendations

Based on analysis of key claim and encounter data fields, Qsource concludes that these key data fields were highly complete and accurate and within acceptable standards. For pharmacy claims, completeness of data fields was within acceptable standards, with the exception of three data fields. Accuracy rates were all within acceptable standards.

Qsource derives from the accuracy of benefit application analyses that determination of accurate processing of claims and encounters is impacted by aberrations in the data submitted by the MCO. However, potential errors in claim/encounter processing accuracy accounted for a negligible percentage of total claims submitted for most services. Finally, Qsource concludes that Community Care, with a total score of 84.7%, demonstrated a moderate level of compliance for truthfulness of claim and encounter data based on documentation of program integrity requirements.

MCO Recommendations

Qsource recommends the actions in **Table 16** for Community Care.

Table 16. Qsource Recommendations for Community Care

Category	Data Field(s) / Service(s)	Issue	Recommendation
Completeness of Key Pharmacy Data Fields	♦ Treating Provider Type ♦ Treating Provider Medicaid Identification ♦ Treating Provider Specialty Code	The completeness rate was below the acceptable rate of 95%.	Ensure completeness for applicable data fields.
Accuracy of Key Pharmacy Data Fields	Class	The accuracy rate was below the acceptable rate of 95%.	Ensure accuracy for applicable data fields.
Accuracy of Benefit Application	♦ Duplicate Claims/ Encounters ♦ Eligibility on the Date of Service	The potential error rate was above the acceptable rate of 5%.	Audit a sample of claim/ encounter detail to attempt to determine the cause of the potential errors.
Services within Benefit Scope and Benefit Limitations by Service Category	♦ Primary Care Provider (PCP) Immunizations ♦ PCP Routine Vision Screening ♦ PCP Routine Hearing Screening ♦ Podiatrist ♦ Durable Medical Equipment	The potential error rate was above the acceptable rate of 5%.	Audit a sample of claim/ encounter detail to attempt to determine the cause of the potential errors.

Table 16. Qsource Recommendations for Community Care

Category	Data Field(s) / Service(s)	Issue	Recommendation
Services for Which Copays Applied by Service Category	♦ Prescription Drugs – $5 per Prescription ♦ Specialist Office Visits – $5 per Visit ♦ Chiropractic Visits – $5 per Visit ♦ Podiatric Visits – $5 per Visit ♦ Emergency Room Services – $10 per Visit, Waived if Admitted ♦ Vision Services – $5 per Visit ♦ Corrective Lenses – $10 per Item ♦ Behavioral Health/Substance Abuse Disorder Specialist Visits – $5 per Visit ♦ Physical Therapy – $5 per Visit ♦ Occupational Therapy – $5 per Visit ♦ Respiratory Therapy – $5 per Visit ♦ Speech Therapy – $5 per Visit	The potential error rate was above the acceptable rate of 5%.	Audit a sample of claim/ encounter detail to attempt to determine the cause of the potential errors.
Data Submission Issues Observed	Claim Line Status Paid at Header	Fee-for-service claims with header status of "P" but a negative or zero paid amount	Audit a sample of claim detail to attempt to determine the cause of the potential errors.
Truthfulness of Claim and Encounter Data	Fraud, Waste, and Abuse Procedure Components	The Compliance Plan did not include documentation of maintaining adequate staffing and resources.	The managed care organization (MCO) could update the Compliance Plan or the SIU [Special Investigations Unit] Antifraud Plan to specifically address maintaining adequate SIU staffing and resources for investigations and corrective action plan development.

Table 16. Qsource Recommendations for Community Care			
Category	**Data Field(s) / Service(s)**	**Issue**	**Recommendation**
Truthfulness of Claim and Encounter Data	Treatment of Recoveries	Policy #CO14029 included provisions for reporting on recoveries and overpayments to the Agency for Health Care Administration (AHCA), but not to Florida Healthy Kids Corporation (FHKC).	The MCO could update Policy #CP14029 to include reporting recoveries and overpayments to FHKC.
Truthfulness of Claim and Encounter Data	Fraud, Waste, and Abuse Procedure Components	The Compliance Plan did not address standards under the contract.	The MCO should update the Compliance Plan to include that written policies and procedures address standards under the contract.
Truthfulness of Claim and Encounter Data	Fraud, Waste, and Abuse Procedure Components	The Compliance Plan did not address standards under the contract.	The MCO should update the Compliance Plan to address the Compliance Committee responsibility to ensure compliance with requirements under the contract.
Truthfulness of Claim and Encounter Data	Fraud, Waste, and Abuse Procedure Components	Policy #CO14017: AHCA MPI Administrative Actions did not address providers identified by FHKC.	The MCO should update Policy #CO14017 to include suspension of payments to providers for which FHKC has identified a credible allegation of fraud.
Truthfulness of Claim and Encounter Data	Disclosures	The Compliance Plan did not address written disclosure of any prohibited affiliation.	The MCO should document the written disclosure of prohibited affiliations in the Compliance Plan.

FHKC Recommendation

Qsource suggests providing additional clarification on coding guidelines for capitation and sub-capitation arrangements and versioning methodology for claim adjustments to the MCO to ensure consistent MCO reporting.

APPENDIX A | Claim/Encounter Data File Layout

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
1	Member ID	10	char	The enrollee's unique 10-digit FHKC member number.
2	Plan ID	9	char	MCO (short name) ID assigned to the plan for use in the 834 file.
3	Medicare Crossover Indicator	1	char	'M' indicates Medicare Part A Crossover, otherwise insert space.
4	Claim Type	1	char	The code used to identify the type of claim record being processed. Please see the following spreadsheet ("Claim Type") for codes and descriptions.
5	Claim Version	4	number	Indicates the claim version number, which is used if the payer adjudicates claims based on a versioning system. This is the number of times a claim as been modified or adjusted incremented each time it has been modified. Number the original claim as 1, and increment by 1 thereafter.
6	Claim Line Status	1	char	Indicates status of the claim line as reported by the payer. "P" = Paid and "D" = Denied
7	Billing Taxonomy	10	char	Please enter the Healthcare Provider Taxonomy Standard Code Set. Please see the following spreadsheet ("Taxonomy Codes") for codes and descriptions.
8	Admit Type	1	char	The code indicating the type and priority of an inpatient admission associated with the service on an intermediary submitted claim. (See spreadsheet "Admit Type Codes" for values)
9	Admit Source	1	char	The code indicating the source of the beneficiary's admission to an Inpatient facility or, for newborn admission, the type of delivery. (See spreadsheet "Admit Source Codes" for values)
10	Admit Date	8	char	Please use YYYYMMDD format. (used on hospital and long term care claims)
11	First Date of Service	8	char	Please use YYYYMMDD format.
12	Last Date of Service	8	char	Please use YYYYMMDD format. For Inpatient and Crisis Stabilization Unit services, this equals the discharge date.
13	Claim Paid Date	8	char	The payment check or warrant date. Please use YYYYMMDD format.

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
14	Total Days	3	number	Total number of days for the statement period of the encounter transaction. This includes encounters where Medicare is the primary payer. (Total Days = Last Date of Service - First Date of Service + 1)
15	Plan Covered Days	3	number	Number of days for the statement period of encounter transactions paid by the plan.
16	Claim Reference Number	25	char	The health plan's internal unique claim record identifier.
17	Patient Account Number	25	char	The hospital's unique patient identifier for an Inpatient services admission as included in Form Locator 3a on a UB-04 paper claim form.
18	Line Item Number	6	char	The line item number from the health plan's internal unique claim (Use line item number zero, '0', for header level reporting)
19	Financial Report Service Category	7	char	Please see the following spreadsheet ("Service Categories") for codes and descriptions. Input using explicit decimal points.
20	Primary Procedure Code	8	char	ICD-9, ICD-10, CPT or Healthcare Common Procedure Coding System (HCPCS) Procedure Code (for Hospital Inpatient use hospital ICD-9 only).
21	Procedure Modifier 1	2	char	2-character procedure code modifier, if applicable.
22	Procedure Modifier 2	2	char	2-character procedure code modifier, if applicable.
23	Procedure Modifier 3	2	char	2-character procedure code modifier, if applicable.
24	Procedure Modifier 4	2	char	2-character procedure code modifier, if applicable.
25	Surgical Procedure Code 2	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
26	Surgical Procedure Code 3	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
27	Surgical Procedure Code 4	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
28	Surgical Procedure Code 5	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
29	Surgical Procedure Code 6	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
30	Surgical Procedure Code 7	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
31	Surgical Procedure Code 8	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
32	Surgical Procedure Code 9	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
33	Surgical Procedure Code 10	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
34	Surgical Procedure Code 11	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
35	Surgical Procedure Code 12	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
36	Surgical Procedure Code 13	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
37	Surgical Procedure Code 14	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
38	Surgical Procedure Code 15	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
39	Surgical Procedure Code 16	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
40	Surgical Procedure Code 17	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
41	Surgical Procedure Code 18	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
42	Surgical Procedure Code 19	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
43	Surgical Procedure Code 20	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
44	Surgical Procedure Code 21	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
45	Surgical Procedure Code 22	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
46	Surgical Procedure Code 23	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
47	Surgical Procedure Code 24	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
48	Surgical Procedure Code 25	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
49	Revenue Code	4	char	Use only for Hospital Inpatient and Hospital Outpatient Services
50	Units of Service	10	number	Please use the units of service referenced in the appropriate Medicaid Coverage and Limitations Handbook. (For Inpatient Hospitalization, Nursing Home, or Hospice, this is the number of covered days; for Pharmacy claims this is the quantity.) **Do not format using commas.**
51	Code ICD Indicator	1	number	Indicates ICD version code. The ICD version must be consistent with codes entered on the claim. Use '0' for ICD-10. FHKC does not anticipate accepting previous version of ICD.
52	Emergency Diagnosis Code	8	char	Diagnosis code for Emergency Department services indicating the beneficiary's initial diagnosis at admission.
53	Admission Diagnosis Code	8	char	Diagnosis code on the institutional claim indicating the beneficiary's initial diagnosis at admission.
54	Admission Diagnosis POA	1	char	Present on Admission Indicator

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
55	Primary Diagnosis	8	char	Primary Diagnosis Code.
56	POA 1	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. Use the UB-04 Data Specifications Manual and the ICD-10-CM Official Guidelines for Coding and Reporting to facilitate the assignment of the POA indicator for each “primary” diagnosis and “other” diagnoses codes reported on claim forms UB-04 and 837 Institutional. See spreadsheet “POA Codes” for valid values.
57	Diagnosis 2	8	char	Additional Diagnosis Code, if applicable.
58	POA 2	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
59	Diagnosis 3	8	char	Additional Diagnosis Code, if applicable.
60	POA 3	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
61	Diagnosis 4	8	char	Additional Diagnosis Code, if applicable.
62	POA 4	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
63	Diagnosis 5	8	char	Additional Diagnosis Code, if applicable.
64	POA 5	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
65	Diagnosis 6	8	char	Additional Diagnosis Code, if applicable.
66	POA 6	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
67	Diagnosis 7	8	char	Additional Diagnosis Code, if applicable.
68	POA 7	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
				hospitals. See spreadsheet “POA Codes” for valid values.
69	Diagnosis 8	8	char	Additional Diagnosis Code, if applicable.
70	POA 8	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
71	Diagnosis 9	8	char	Additional Diagnosis Code, if applicable.
72	POA 9	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
73	Diagnosis 10	8	char	Additional Diagnosis Code, if applicable.
74	POA 10	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
75	Diagnosis 11	8	char	Additional Diagnosis Code, if applicable.
76	POA 11	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
77	Diagnosis 12	8	char	Additional Diagnosis Code, if applicable.
78	POA 12	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
79	Diagnosis 13	8	char	Additional Diagnosis Code, if applicable.
80	POA 13	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
81	Diagnosis 14	8	char	Additional Diagnosis Code, if applicable.
82	POA 14	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
83	Diagnosis 15	8	char	Additional Diagnosis Code, if applicable.
84	POA 15	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
85	Diagnosis 16	8	char	Additional Diagnosis Code, if applicable.
86	POA 16	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
87	Diagnosis 17	8	char	Additional Diagnosis Code, if applicable.
88	POA 17	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
89	Diagnosis 18	8	char	Additional Diagnosis Code, if applicable.
90	POA 18	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
91	Diagnosis 19	8	char	Additional Diagnosis Code, if applicable.
92	POA 19	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
93	Diagnosis 20	8	char	Additional Diagnosis Code, if applicable.
94	POA 20	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
95	Diagnosis 21	8	char	Additional Diagnosis Code, if applicable.
96	POA 21	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
97	Diagnosis 22	8	char	Additional Diagnosis Code, if applicable.

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
98	POA 22	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
99	Diagnosis 23	8	char	Additional Diagnosis Code, if applicable.
100	POA 23	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
101	Diagnosis 24	8	char	Additional Diagnosis Code, if applicable.
102	POA 24	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
103	Diagnosis 25	8	char	Additional Diagnosis Code, if applicable.
104	POA 25	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
105	Treating Provider Type	2	char	Please see the following spreadsheet (“Provider Types”) for codes and descriptions. (include leading zeros)
106	Treating Provider NPI	10	char	NPI (National Provider Identifier) of the treating provider, prescribing provider or hospital
107	Treating Provider Medicaid ID	9	char	Florida Medicaid Provider ID of the treating provider, prescribing provider or hospital
108	Treating Provider Specialty Code	3	char	3-character Specialty Code of the treating Provider (include leading zeros) (See contract for Provider Network Files report for valid values.)
109	Billing Provider Type	2	char	Please see the following spreadsheet (“Provider Types”) for codes and descriptions. (include leading zeros)
110	Billing Provider NPI	10	char	NPI (National Provider Identifier) of the billing provider
111	Billing Provider Medicaid ID	9	char	Florida Medicaid Provider ID of the billing provider

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
112	Billing Provider Specialty Code	3	char	3-character Specialty Code of the billing provider (include leading zeros) (See contract for Provider Network Files report for valid values.)
113	Facility Provider Type	2	char	Please see the following spreadsheet (“Provider Types”) for codes and descriptions. (include leading zeros)
114	Facility Provider NPI	10	char	NPI (National Provider Identifier) of the facility provider
115	Facility Provider Medicaid ID	9	char	Florida Medicaid Provider ID of the facility provider
116	Place of Service	2	char	Two-digit code that specifies the place of service or treatment. See spreadsheet “Place of Service Codes” for codes.
117	TPL Amount	10	number	Third Party Liability amount paid for costs associated with the claim. Format with an explicit decimal point and two decimal places, but no explicit commas or dollar signs.
118	Billing Date	8	char	The date the claim was billed to the plan
119	Billed Amount	10	number	Billed amount for costs associated with the claim. Format with an explicit decimal point and two decimal places, but **no explicit commas or dollar signs**.
120	Patient Responsibility Amount	10	number	The amount that the recipient is responsible for paying, if any.
121	Amount Paid	10	number	Amount paid for costs of actual services associated with the claim for all Reimbursement Arrangements. Format with an explicit decimal point and two decimal places but **no explicit commas or dollar signs**. The amount paid should correspond to the amount paid type described below.
122	Amount Paid Type	1	char	“A” = Actual amount paid; “R” = Repriced to fee-for service amount; “U” = No actual or repriced amount available. It is expected that most claim amounts will be the actual amount paid, with re-priced amounts confined to sub-capitated services where the actual payment amount is unknown.
123	NDC	11	char	National Drug Code Identification number of the dispensed medication. Use only for Pharmacy services.
124	Class	3	char	Therapeutic Class Code. Use only for Pharmacy services.

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
125	Prescription Number	12	char	Prescription/Service Reference number. Use only for Pharmacy services.
126	Primary Pharmacy ID	12	char	NPI number that identifies the pharmacy, chain, or Preferred Provider Organization (PPO) that the member used in order to obtain benefits. Use only for Pharmacy services.
127	Days' Supply	3	number	The number of days of medication the physician prescribed for this claim.
128	Hospital Discharge Status	2	char	Two-digit code that identifies where the patient is at the conclusion of a health care facility encounter. This should be entered for all Hospital Inpatient and Hospital Outpatient encounters. See spreadsheet "Discharge Codes" for codes.
129	Hospital Bill Type Code	4	char	Three-digit code that provides information concerning hospital bills. This should be entered for all Hospital Inpatient and Hospital Outpatient encounters. See spreadsheet "Bill Types" for codes.
130	Base APR-DRG	3	char	Three-digit APR-DRG code as determined by the health plan. This should be entered for all Hospital Inpatient and Hospital Outpatient encounters, if available.
131	APR-DRG Severity of Illness	1	number	1 = Minor; 2 = Moderate; 3 = Major; 4 = Extreme. This supplements the Base APR-DRG.
132	APR-DRG Risk of Mortality	1	number	1 = Minor; 2 = Moderate; 3 = Major; 4 = Extreme. This supplements the Base APR-DRG.
133	EAPG Code	5	char	Enter the EAPG code, based on the EAPG Core Grouping Software output, for the service(s) being rendered. Enter five digits, including the leading "0". (see spreadsheet "EAPG Codes" for codes)
134	EAPG Relative Weight	6	number	Based on the EAPG that has been entered, the weight used in the calculation. (see spreadsheet "EAPG Codes" for values)
135	Provider Policy Adjustor	6	number	Indicator of whether the provider receives an outpatient high volume adjustment in its EAPG conversion factor. If there is no adjustment, this will be set to 1 and shown as 1.0000.
136	Discounting Factor	6	number	The Final Discount Adjustment as a percentage (the combined adjustment = Bundling Adjustor x Ancillary Procedure Adjustor x Significant Procedure Adjustor x Bilateral Procedure Adjustor x Terminated Procedure Adjustor)

APPENDIX B | Community Care Program Integrity Standard Tool

2021 Periodic Audit: Community Care Plan (Community Care)					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
1. Fraud, Waste, and Abuse Procedure Components – 1 42 Code of Federal Regulations (CFR) 438.608(a)(1)(i)-(iv) Medical Services Contract (MSC) 25(a)(i)-(iv)	The managed care organization (MCO) must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include a compliance program that includes, at a minimum, all of the following elements: a. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable federal and state requirements b. The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the chief executive officer and the board of directors c. The establishment of a Regulatory Compliance Committee on the board of directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract d. A system for training and education for the compliance officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract	☐ a. Written policies, procedures, and standards of conduct ☑ b. Designation of a compliance officer ☐ c. Regulatory Compliance Committee on the board of directors and at the senior management level ☑ d. System for training and education on federal and state standards and requirements under the contract ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**0.500**

2021 Periodic Audit: Community Care Plan (Community Care)					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Findings	The Compliance Plan 2019–2020 and 2020–2021 (Compliance Plan) described written policies and procedures that governed the compliance program and the Business Ethics and Conduct Policy, which reinforced the MCO's commitment to compliance with federal and state laws, regulations, guidelines, and policies and included Standards of Conduct that ensured clear expectations of behaviors that must be followed. However, standards under the contract were not addressed. The Compliance Plan described the appointment of a Compliance Officer who was responsible for oversight and operation of the compliance program, including ensuring compliance with requirements under the contract, and who reported to the Chief Executive Officer and the governing board. The Compliance Plan described the Compliance Committee that reported to the governing board and was responsible for oversight of the compliance program. However, standards under the contract were not addressed. The Compliance Plan also included effective training and education as a goal of the compliance program and described compliance, and fraud, waste, and abuse training for employees upon hire and annually thereafter. Policy #CO14003: Training included a comprehensive description of the compliance training program designed to provide education on compliance program requirements, including regulatory and contractual compliance.				
Strength	1. Policy #CO14003 provided a detailed description of the compliance training program for employees. 2. The MCO maintained comprehensive compliance policies and procedures.				
AON	1. The MCO should update the Compliance Plan to include that written policies and procedures address standards under the contract. 2. The MCO should update the Compliance Plan to address the Compliance Committee responsibility to ensure compliance with requirements under the contract.				
Suggestion	None were identified.				
2. Fraud, Waste, and Abuse Procedure Components – 2 42 CFR 438.608(a)(1)(v)-(vii) MSC 25(a)(v)-(viii)	The MCO must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include a compliance program that includes, at a minimum, all of the following elements: a. Effective lines of communication between the compliance officer and the organization's employees, as evidenced by some formal policy b. Enforcement of standards through well-publicized disciplinary guidelines	☑ a. Effective lines of communication between compliance officer and MCO employees ☑ b. Enforcement of standards ☑ c. Non-retaliation policies against any individual that reports violations ☑ d. Establishment and implementation of procedures and system with dedicated staff	**0.250** **0.250** **0.250** **0.250**	**1.000**	**1.000**

2021 Periodic Audit: Community Care Plan (Community Care)					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
	c. Non-retaliation policies against any individual that reports violations of the MCO's fraud and abuse policies and procedures or suspected fraud and abuse d. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence of compliance issues, and ongoing compliance with the requirements under the contract	☐ Not Applicable	**0.000**		

Findings	The Compliance Plan referred to lines of communication between the Compliance Officer and the MCO's employees, which were described in the Business Ethics and Conduct Policy. The Compliance Plan referred to corrective, remedial, and disciplinary action for all employees who failed to comply with their obligations. The Business Ethics and Conduct Policy and the Anti-Fraud Plan 2019–2020 included non-retaliation policies against individuals who reported compliance violations. The Anti-Fraud Plan included a comprehensive description of procedures and the system with a dedicated Special Investigations Unit (SIU) for monitoring and auditing of compliance risks, prompt response to compliance issues, investigation of potential compliance audits, and corrections of problems. The Compliance Officer was noted as being responsible for maintaining an anti-fraud plan and program integrity procedures per state and federal regulations, as well as contract requirements.
Strength	None were identified.
AON	None were identified.
Suggestion	None were identified.

2021 Periodic Audit: Community Care Plan (Community Care)					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
3. Fraud, Waste, and Abuse Procedure Components – 3 42 CFR 438.608(a)(3)(i)-(ii), (4)-(6) MSC 18-1, 25(b)-(c)	The MCO must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following: a. Provision for prompt notification to Florida Healthy Kids Corporation (FHKC) when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility within five business days of receipt of such information, including: (i) changes in the enrollee's residence; and (ii) the death of an enrollee b. Provision for notification to FHKC when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO c. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis d. In the case of the MCO making or receiving annual payments under the contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the *False Claims Act* and other federal and state laws described in section 1902(a)(68) of the *Social Security Act*, including information about rights of employees to be protected as whistleblowers	☑ a. Provision for notification to FHKC about a change in an enrollee's circumstances affecting eligibility ☑ b. Provision for notification to FHKC about a change in a network provider's circumstances ☑ c. Provision for a method to verify services represented as delivered were received by enrollees ☑ d. Provision for written policies that provide detailed information about the *False Claims Act* and other federal and state laws ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**1.000**

2021 Periodic Audit: Community Care Plan (Community Care)					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Findings	Standard Operating Procedure (SOP): Florida Healthy Kids Eligibility addressed the process by which discrepancies in enrollee information were identified. A CCP Florida Healthy Kids Enrollment Discrepancy Report sample addressed reporting of enrollee information discrepancies to FHKC. The Anti-Fraud Plan noted that the MCO would disclose to the Medicaid Program Integrity (MPI) Unit and FHKC any providers against whom the MCO had taken action to limit the ability of the provider to participate in the MCO's network. Policy #CO14055: Verification of Services described the methods to verify services provided by network providers had been provided to MCO enrollees. The Anti-Fraud Plan also described the Concierge Care Coordination (C3) model, including ongoing verification of home-based services received by enrollees. The Anti-Fraud Plan described the *False Claims Act* and other federal and state laws and whistleblower protection as components of the Compliance and Fraud Awareness Training Program conduced within 30 days of new hire and annually thereafter.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				
4. Fraud, Waste, and Abuse Procedure Components – 4 42 CFR 438.608(a)(7)-(8) MSC 25(e)	The MCO must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following: a. Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit b. Provision for the MCO's suspension of payments to a network provider for which FHKC or the Agency for Health Care Administration (AHCA) determines there is a credible allegation of fraud in accordance with 42 CFR 455.23	☑ a. Provision for the prompt referral of any potential fraud, waste, or abuse ☐ b. Provision for the MCO's suspension of payments to a network provider for which FHKC or AHCA determines there is a credible allegation of fraud ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**0.500**
Findings	The Anti-Fraud Plan indicated that the Compliance Officer was responsible for reporting suspected or confirmed fraud, waste, and abuse to the MPI Unit and to FHKC as required by the MCO's contract with FHKC. Policy #CO14029: Fraud, Waste, and Abuse Reporting included the procedures for reporting suspected and/or confirmed instances of fraud, abuse, and waste as required by AHCA and FHKC. Policy #CO14017: AHCA MPI Administrative Actions included a detailed description of the process by which payments to network providers for which AHCA determines there is an credible allegation of fraud are suspended. However, providers identified by FHKC were not addressed.				

2021 Periodic Audit: Community Care Plan (Community Care)					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Strength	None were identified.				
AON	The MCO should update Policy #CO14017 to include suspension of payments to providers for which FHKC has identified a credible allegation of fraud.				
Suggestion	None were identified.				
5. Fraud, Waste, and Abuse Procedure Components – 5 MSC 25(d)	The MCO must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include a provision for prompt reporting to FHKC of information the MCO obtains indicating fraud or potential fraud by a provider, subcontractor, applicant, or enrollee.	☑ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**1.000**
Findings	The Anti-Fraud Plan indicated that the Compliance Officer was responsible for reporting suspected or confirmed fraud, waste, and abuse to FHKC as required by the MCO's contract with FHKC. Policy #CO14029: Fraud, Waste, and Abuse Reporting included the procedures for reporting suspected and/or confirmed instances of fraud, abuse, and waste as required by AHCA and FHKC.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				
6. Fraud, Waste, and Abuse Procedure Components – 6 MSC 25(f)	The MCO must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include policies and procedures to maintain adequate staffing and resources to investigate unusual incidents and to develop corrective action plans to assist the MCO with preventing and detecting potential fraud and abuse.	☑ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**1.000**
Findings	The Compliance Plan included an organizational chart demonstrating reporting responsibilities for Compliance/SIU staff and described the positions of the SIU Manager, SIU Coder, and Compliance Analyst and their responsibilities in detail. However, no documentation of maintaining adequate staffing and resources was included.				
Strength	None were identified.				
AON	None were identified.				

2021 Periodic Audit: Community Care Plan (Community Care)					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Suggestion	The MCO could update the Compliance Plan or the SIU Antifraud Plan to specifically address maintaining adequate SIU staffing and resources for investigations and corrective action plan development.				
7. Fraud, Waste, and Abuse Procedure Components – 7 MSC 25	The MCO must cooperate in any investigation by FHKC or any state or federal entities and any subsequent legal action that may result from such an investigation.	☑ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**1.000**
Findings	The Anti-Fraud Plan addressed that the MCO would cooperate fully in any investigation by federal and state oversight agencies and any subsequent legal action that may result from such an investigation.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				
8. Provider Screening and Enrollment Requirements 42 CFR 438.608(b) MSC 24-3	The MCO must ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of part 455, subparts B and E of CFR chapter 42.	☑ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**1.000**
Findings	Policy #CO14030: Exclusion Database Screening and AHCA Ineligible Providers described the process by which the MCO ensured it did not include non-Medicaid-eligible providers in its network.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				

2021 Periodic Audit: Community Care Plan (Community Care)					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
9. Disclosures 42 CFR 438.608(c)(1)-(3)	The MCO must: a. provide written disclosure of any prohibited affiliation under 42 CFR 438.610; b. provide written disclosures of information on ownership and control required under 42 CFR 455.104; and c. report to FHKC within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.	☐ a. Provided written disclosure of any prohibited affiliation ☑ b. Provided written disclosures of information on ownership and control ☑ c. Reported to FHKC within 60 calendar days when the MCO identified the capitation payments or other payments in excess ☐ Not Applicable	**0.333** **0.333** **0.333** **0.000**	**1.000**	**0.667**
Findings	The Compliance Plan indicated that the MCO did not knowingly employ or contract with an individual or entity who was an affiliate of a person described in 42 CFR 438.610. However, written disclosure of any prohibited affiliation was not addressed. Policy #CR1001: Provider Credentialing and Recredentialing noted written disclosure of information on ownership and control. Policy #FIN033: Florida Healthy Kids Overpayments to CCP described the process by which overpayments were identified and refunded to FHKC within 45 days.				
Strength	None were identified.				
AON	The MCO should document the written disclosure of prohibited affiliations in the Compliance Plan.				
Suggestion	None were identified.				
10. Treatment of Recoveries 42 CFR 438.608(d)(2)-(3) MSC 24-7-3(a)(i)-(ii)	The MCO must: a. have a mechanism for a network provider to report in writing to the MCO when it has received an overpayment, to return the overpayment to the MCO within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO in writing of the reason for the overpayment; and b. report annually to FHKC on the MCO's recoveries of overpayments.	☐ a. Mechanism for network provider to report to MCO receipt of overpayment and to return overpayment to MCO within 60 calendar days ☑ b. Reported annually to FHKC on the MCO's recoveries of overpayments ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**0.500**

2021 Periodic Audit: Community Care Plan (Community Care)					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Findings	The provider Master Services Agreement addressed overpayments identified by the MCO, but did not include mechanisms for providers to report overpayments to the MCO. Policy #CO14029 included provisions for reporting on recoveries and overpayments to AHCA, but not to FHKC. The FHKC Reporting Matrix demonstrated the annual reporting of overpayments and recoveries to FHKC.				
Strength	None were identified.				
AON	The MCO should update the provider manual or Master Services Agreement to address mechanisms for providers to report and refund overpayments to the MCO within 60 calendar days of identification and include the reason for the overpayment.				
Suggestion	The MCO could update Policy #CP14029 to include reporting recoveries and overpayments to FHKC.				
11. Prohibited Affiliations – 1 42 CFR 438.610(a)(1)-(2) MSC 4-4-1	The MCO must not knowingly have with the following a relationship of the type described in 42 CFR 438.610(c)—including a director, officer, or partner of the MCO; a subcontractor of the MCO as governed by 42 CFR 438.230; a person with beneficial ownership of five percent or more of the MCO's equity; and a network provider or person with an employment, consulting, or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's obligations under its contract with FHKC: a. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 b. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in 42 CFR 438.610(a)	☑ a. An individual or entity that was debarred, suspended, or otherwise excluded from participating in procurement and nonprocurement activities ☑ b. An individual or entity who is an affiliate ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**1.000**
Findings	The Compliance Plan indicated that the MCO would not knowingly employ or contract with individuals or entities or affiliates of these individuals or entities who were on the discriminatory vendor list maintained by the Department of Management Services. Policy #CO14030 described the process by which the System for Award Management (SAM) was screened monthly and annually to identify these individuals, entities, and affiliates.				

2021 Periodic Audit: Community Care Plan (Community Care)					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				
12. Prohibited Affiliations – 2 42 CFR 438.610(b)	The MCO must not have a relationship with an individual or entity that is excluded from participation in any federal healthcare program under section 1128 or 1128A of the *Social Security Act*.	☑ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**1.000**
Findings	The Compliance Plan noted that the MCO would not knowingly employ or contract with individuals or entities excluded from participation in any federal healthcare program under sections 1128 and 1128A of the *Social Security Act*. Policy #CO14030 described the process by which the Department of Health and Human Services (HHS) Office of Inspector General (OIG) federal List of Excluded Individuals and Entities (LEIE) was screened annually and on a monthly basis to ensure the MCO did not pay, employ, or contract with individuals on the exclusion list.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				
Program Integrity for Periodic Audit			**84.7%**	**12.000**	**10.167**

APPENDIX C | Response to Periodic Audit Draft

Relevant responses from the MCO are included in this appendix of the final 2021 Periodic Audit Report to reflect any comments or feedback following the MCO's review of the draft report. Qsource reviewed the MCO's feedback before compiling this final report. A description of Qsource's response to the MCO's feedback, if applicable, is also included. Responses were not altered from the original plan submission.

Community Care provided the following documents in PDF format and when applicable, identified specific sections supporting its efforts for the periodic audit:

CCP Anti Fraud Plan 2021 2022 Clean 101521 - Page 14
CCP Compliance Plan 2021 2022 Clean 101521 - Pages 3 & 5 & 11
CCP FHK Provider Manual Effective - Page 19
CO14017 AHCA MPI Administrative Actions
CO14029 Fraud Waste and Abuse Reporting

Further, Community Care addressed findings for Tables 5-7 and Table 9:

Summary of the findings:

Table 5:

Table 5. Duplicated Payment	
Duplicate Claims/Encounters Reported	676
Total Duplicate Claims/Encounters Paid	641
Potential Error Rate	94.82%
Paid Duplicates as % of Total Claims/Encounters	**0.48%**

- **T5 Duplicated Payment (PDF – pg. 14) –** see screen shots in Excel with further details
  - **Tapestry Claims:**
    - 3 Claims reviewed in Epic
      - All 3 were found to have an exact duplicate claim paid under another claim ID
      - After Claims Dept review, the following was determined:

    - 2 Claims were found to have been a duplicate payment
    - 1 Claim was found not to be a duplicate payment, since provider billed with Modifier 91

- **CARISK Claims:**
    - 4 Claims – In 2020, behavioral/mental health services including claims processing/encounters were delegated to our subcontractor, Carisk Behavioral Health.
    - As of 2021, CCP handles the entire behavioral/mental health services processes and as such the encounter process/copay application have been in line with the FHK requirements.

Table 6:

Table 6. Eligibility on Date of Service	
Total Services for Which Enrollee Not Eligible on Date of Service	376
Ineligible Services Paid	327
Potential Error Rate	86.97%
Paid Ineligible Services as % of Total Claims/Encounters	**0.24%**

- **T6 Eligibility on DOS (PDF – pg. 15) –** see screen shots in Excel for further details
    - **Tapestry Claims:**
        - 9 claims provided by Qsource reviewed in EPIC
            - Review of coverage found member did not have coverage for DOS
            - After further review, the following was determined:
                - Coverage issue due to reinstatement of member, core system updated accordingly
    - **iCare Claims:**
        - 1 claim – Deferred to Partner in Care – iCare for further review
            - After review by iCARE, the following was determined:
                - Claim was confirmed to be paid for ineligible member; our vision subcontractor was placed on a CAP in January 2021 and eligibility issues were resolved in Q1.

Table 7:

Table 7. Services within Benefit Scope and Benefit Limitations by Service Category				
Service Category	**Services Within Benefit Scope and Benefit Limitations Reported***	**Services Within Benefit Scope and Benefit Limitations Not Paid**	**Potential Error Rate**	**Services Within Benefit Scope and Benefit Limitations Not Paid as % of Total Claims/ Encounters**
Primary Care Provider (PCP) Office Visit	17,516	49	0.28%	**0.04%**
PCP Well-Child Care	890	1	0.11%	**0%**
PCP Immunizations	7,707	1,074	**13.94%**	**0.80%**
PCP Routine Vision Screening	1,583	1,515	**95.70%**	**1.13%**
PCP Routine Hearing Screening	3,784	2,789	**73.71%**	**2.08%**
Specialist Office Visit	16,615	56	0.34%	**0.04%**
Chiropractor	121	0	0%	**0%**

- **T7 Immunizations (PDF – pg. 15 to pg. 16) –** see screen shots in Excel for further details
  - **Tapestry Claims:**
    - 10 claims reviewed in Epic
      - All found to have been denied with EOB Code INC3 (DENY NOT PAYABLE UNDER MEDICAID)
      - After Claims Dept review, the following was determined:
        - 10 Claims were found to have been properly denied since code was not in the Fee Schedule and was not a carve out

- **T7 Vision Screening (PDF – pg. 15 to pg. 16) –** see screen shots in Excel for further details
  - **Tapestry Claims:**
    - 10 claims reviewed in Epic
      - All found to have been denied with EOB Code INC3 (DENY NOT PAYABLE UNDER MEDICAID)
      - After Claims Dept review, the following was determined:
        - 10 Claims were found to have been properly denied since code was not in the Fee Schedule and was not a carve out

- **T7 Hearing Screening (PDF – pg. 15 to pg. 16) –** see screen shots in Excel for further details
  - **Tapestry Claims:**
    - 10 claims reviewed in Epic
      - All found to have been denied with EOB Code INC3 (DENY NOT PAYABLE UNDER MEDICAID)

        - After Claims Dept review, the following was determined:
            - 10 Claims were found to have been properly denied since code was not in the Fee Schedule and was not a carve out

- **T7 Podiatrist (PDF – pg. 15 to pg. 16) –** see screen shots in Excel for further details
    - **Magellan Claims:**
        - 10 Claims - Deferred to Partner in Care – Magellan for further review
            - After review by Magellan, the following was determined:
                - All 10 encounters with provider type 27 and billing provider type 20 were denied and therefore copays were not applied as deemed accurate.

- **T7 DME (PDF – pg. 15 to pg. 16) –** see screen shots in Excel for further details
    - **Magellan Claims:**
        - 10 Claims - Deferred to Partner in Care – Magellan for further review
            - After review by Magellan the following was determined:
                - All 10 encounters were denied and therefore copays were not applied as deemed accurate.

Table 9:

Table 9. Services for Which Copays Applied by Service Category				
Service Category	**Total Services for Which Copays Applied Reported**	**Services for Which Copays Not Applied**	**Potential Error Rate**	**Services for Which Copays Not Applied as % of Total Claims/ Encounters**
Prescription Drugs – $5 per Prescription	12,096	4,261	35.23%	NA
Primary Care Provider Visits*/** (excluding well-child care, preventive visits, immunizations, routine hearing and vision screening) – $5 per Visit	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Specialist Office Visits – $5 per Visit	8,468	7,371	87.05%	5.51%
Chiropractic Visits – $5 per Visit	100	12	12.00%	0.01%
Podiatric Visits – $5 per Visit	178	27	15.17%	0.02%

- **T9 Prescription Drugs (PDF - pg. 18) –** see screen shots in Excel for further details
  - **Magellan Claims:**
    - 10 Claims - Deferred to Partner in Care – Magellan for further review
      - After review by Magellan the following was determined:
        - 6 encounters with no copay applied were appropriate as they were for American Indian or Alaskan Native for which copays do not apply per contract.
        - 4 encounters contained/reflected a copay, however, less than the $5 copay was applied.

- **T9 PCP Visit (PDF - pg. 18) –** see screen shots in Excel for further details
  - **Tapestry Claims:**
    - 10 claims reviewed in EPIC
      - All claims were found to have no copay applied
      - After Claims Dept review, the following was determined:
        - 10 Claims were found to be Not Applicable for a copay since no CCP has no copays for PCP Visits as a value-added benefit.

- **T9 Specialist Visit (PDF - pg. 18) –** see screen shots in Excel for further details
  - **CARISK Claims:**

        - 10 Claims - In 2020, behavioral/mental health services including claims processing/encounters were delegated to our subcontractor, Carisk Behavioral Health.
        - As of 2021, CCP handles the entire behavioral/mental health services processes and as such the encounter process/copay application have been in line with the FHK requirements.

- **T9 Chiropractor (PDF - pg. 18) –** see screen shots in Excel for further details
    - **Tapestry Claims:**
        - 5 claims reviewed in EPIC
            - All claims were found to have no copay applied
            - After Claims Dept review the following was determined:
                - 5 Claims were found to each have 2 Dates of Services included
                - $10 for 2 days of service 2/28/2020, 3/4/2020
                - $10 for 2 days of service 5/26/2020, 5/28/2020
                - $10 for 2 days of service5/27/2020, 5/29/2020
                - $10 for 2 days of service 6/12/2020, 6/15/2020
                - $10 for 2 days of service 10/26/2020, 10/28/2020

        - 2 claims reviewed in EPIC
            - Logic was updated to have Line "0" as Denied Status for Denied Claims
            - Update has been applied since Q2 2021 submissions
                - *Issue has been resolved*

- **T9 Podiatry (PDF - pg. 18) –** see screen shots in Excel for further details
    - **Tapestry Claims:**
        - 10 claims reviewed in EPIC
            - Logic was updated to have Line "0" as Denied Status for Denied Claims
            - Update has been applied since Q2 2021 submissions
                - *Issue has been resolved*

- **T9 ER (PDF - pg. 18) –** see screen shots in Excel for further details
    - **Tapestry Claims:**
        - 4 claims reviewed in EPIC

- All claims were found to have no copay applied
- After Claims Dept review the following was determined:
  - 4 Claims were found to have the Copay waived due to State of Emergency

- 6 claims reviewed in EPIC
  - Logic was updated to have Line "0" as Denied Status for Denied Claims
  - Update has been applied since Q2 2021 submissions
    - *Issue has been resolved*

- **T9 Vision (PDF - pg. 18) –** see screen shots in Excel for further details
  - **iCare Claims:**
    - 10 Claims - Deferred to Partner in Care – iCare for further review
      - After review by iCare the following was determined:
        - 10 Encounters had copay applied, reporting issue
        - Vision subcontractor was placed on a CAP in January 2021 and reporting issues were resolved in Q1.
- **T9 Corrective Lenses (PDF - pg. 18) –** see screen shots in Excel for further details
  - **iCare Claims:**
    - 10 Claims - Deferred to Partner in Care – iCare for further review
      - After review by iCare the following was determined:
        - 3 Encounters did not have the copay applied
        - 7 Encounters had copays applied, reporting issue
        - Vision vendor was placed on a CAP in January 2021 and reporting issues were resolved in Q1
- **T9 BH_SA Visits (PDF - pg. 18) –** see screen shots in Excel for further details
  - **CARISK Claims:**
    - 10 Claims - In 2020, behavioral/mental health services including encounters were delegated to our subcontractor, Carisk Behavioral Health.
    - As of 2021, CCP handles the entire behavioral/mental health services processes and as such the encounter process/copay application have been in line with the FHK requirements.

- **T9 PT (PDF - pg. 18) –** see screen shots in Excel for further details
  - **HN1 Claims:**

        - 10 Claims - Deferred to Partner in Care – HN1 for further review
            - After review by HN1 the following was determined:
                - 8 Encounters had Copays applied and in the actual encounter but not in the quarterly QSource file due to a mapping issue with their provider case rate contracts
                - 2 Encounters had Copays applied but not in the actual encounter nor in the quarterly QSource file due to a mapping issue with their provider case rate fee contracts

- **T9 OT (PDF - pg. 18) –** see screen shots in Excel for further details
    - **HN1 Claims:**
        - 10 Claims - Deferred to Partner in Care – HN1 for further review
            - After review by HN1 the following was determined:
                - 8 Encounters had Copays applied and in the actual encounter but not in the quarterly QSource file due to a mapping issue with their provider case rate fee schedule
                - 2 Encounters had Copays applied but not in the actual encounter nor in the quarterly QSource file due to a mapping issue with their provider case rate contracts

- **T9 RT (PDF - pg. 18) –** see screen shots in Excel for further details
    - **Tapestry Claims:**
        - 10 claims reviewed in EPIC
            - All claims were found to have no copay applied
            - After Claims Dept review the following was determined:
                - 10 Claims found to have Services provided at the PCP office - No Copay required

- **T9 ST (PDF - pg. 18) –** see screen shots in Excel for further details
    - **HN1 Claims:**
        - 10 Claims - Deferred to Partner in Care – HN1 for further review
            - After review by HN1, the following was determined:
                - 10 Encounters had copays applied and was reflected in the actual encounter but not in the quarterly QSource file due to a mapping issue with the provider case rate contracts

- **Status P_Amt Pd 0 (Excel tab - *Status P_Amt Pd 0*)**
  - **Tapestry Claims:**
    - 10 claims reviewed in EPIC
      - Logic was updated to have Line "0" as Denied Status for Denied Claims
      - Update has been applied since Q2 2021 submissions
        - *Issue has been resolved*