2021

Periodic Audit

Report

Simply Healthcare Plans, Inc.

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
CEO ..... Chief Executive Officer
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
ICD ..... International Classification of Diseases
ID ..... Identification
MCO ..... Managed Care Organization

[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.*

MPI.....Medicaid Program Integrity
MSC.....Medical Services Contract
NCCI.....National Correct Coding Initiative
NDC.....National Drug Code
NPI.....National Provider Identifier
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
SIU.....Special Investigations Unit
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 Simply Healthcare Plans, Inc. (hereafter referred to as Simply Healthcare) 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, Simply Healthcare 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 Simply Healthcare:

- 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 Simply Healthcare's key claim data fields were highly complete and accurate, all exceeding 97.0%. Completeness and accuracy rates for all key encounter data fields were over 96.0%. Completeness rates for key pharmacy data fields were over 99.0%, with the exception of National Drug Code (NDC) and Class at 88.0% and Primary Pharmacy Identification (ID) and Days' Supply at 88.2%.

For the review of medical records, date of service, Current Procedural Terminology (CPT) procedure codes, and International Classification of Diseases (ICD) diagnosis codes were highly accurate between the medical record and the electronic claim submission, while the accuracy rate for performing provider National Provider Identifier (NPI) was below the acceptable 95% standard.

For accuracy of benefit application, the number of duplicate claims and encounters submitted was fairly minimal (15,327) when compared to total claims and encounters submitted. The vast majority of the duplicate claims were coded as paid but had a header paid amount of zero, suggesting they may actually have been denied. Removing these claims from the analysis, only 173 duplicate fee-for-service claims were coded as paid, resulting in a potential error rate of 0.1%. All duplicates coded as paid represented only 0.3% of total claims and encounters.

For eligibility of the enrollee on the date of service, 13,883 claims for services when the enrollee was not eligible were submitted, with 1,600 coded as paid, resulting in a potential error rate of 11.5%. However, about one-third of these claims with a paid header status had a paid amount less than or equal to zero, indicating that they may actually have been denied. Taking these claims out of the analysis, the potential error rate dropped to 7.0%. These paid claims accounted for a negligible percentage of total claims submitted (0.1%).

For services within benefit scope and benefit limitations paid, of the 19 applicable service categories for which benefits would typically be paid, 15 service categories (78.9%) demonstrated potential error rates over the acceptable 5% rate. For 4 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 for these services were negligible in comparison to total claims and encounters, below 0.8% for all categories except Diagnostic Testing (2.3%).

For services over benefit limitations, the potential error rate was high for one of three applicable service categories, Podiatric Services – Two Visits per Month, at 32.5%. However, this only accounted for 37 claims, less than 0.01% of total claims/encounters.

For services with applicable copays, the potential error rate exceeded the acceptable 5% rate across all but one service category, ranging from 9.2% to 94.5%. In the majority of cases, appropriate copays applicable to specific services were not identified in the patient responsibility amount field in the data submissions.

The truthfulness assessment was based on an evaluation of compliance with program integrity regulatory and contractual requirements. Simply Healthcare's overall score on the program integrity standard was 86.8%. For this assessment, four strengths were identified related to Simply Healthcare's Florida-specific Compliance Plan and Special Investigations Unit (SIU) Antifraud Plan, which also were noted as thorough and comprehensive. Three suggestions were noted, related to documenting the requirement to notify FHKC of changes in provider circumstances, fraud or potential fraud, and excess payments. Last, four areas of noncompliance (AONs) were identified, related to notifying FHKC of changes in enrollee circumstances, suspending payments to providers identified by FHKC with a credible allegation of fraud, and the calendar day notification requirement for overpayments.

Conclusions

Based on analyses, Qsource concludes that Simply Healthcare's data submission for key claim and encounter fields enabled a confident determination that the data for these fields were highly complete and accurate. However, key pharmacy data fields were not highly complete but were highly accurate. The medical record review demonstrated that electronic claims submissions were consistent with the medical record in most cases.

Aberrations in data submitted by Simply Healthcare 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 Simply Healthcare 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/encounters 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. In addition, the MCO should address the issues of fee-for-service claims with a paid header status, but a zero or negative amount paid. Qsource also recommends that Simply Healthcare address the three suggestions and four 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. Simply Healthcare 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) serving the Florida Healthy Kids population. The third MCO (Community Care Plan) did not report any physician encounters in CY 2020. With a desired margin of error of 0.05 and level of confidence of 95%, a sample of 384 encounter records was selected with a 10% oversample of 39 records, for a total of 423 distinct encounters combined from both MCOs, with 122 representing Simply Healthcare. Qsource requested that the MCO secure medical records associated with these encounters. The records were reviewed to confirm that key electronic encounter data were supported by the appropriate medical record.

Qsource first identified if the appropriate medical record was available, then validated the following data in each medical record as compared to the electronic encounter data:

- Performing provider name match to National Provider Identifier (NPI) number
- Date of service
- All CPT procedure codes
- The first three ICD-10 diagnosis codes for each encounter

As with completeness and accuracy rates, a targeted error rate below 5% was applied for medical record review analysis, based on CMS EQR Protocol 5.

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 Simply Healthcare 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 Simply Healthcare 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 Simply Healthcare.

Table 2. Completeness and Accuracy Rates—Claim Lines Submitted by Simply Healthcare

Field	Present	Completeness Rate	Accurate	Accuracy Rate*
	N=2,008,430			
Member Identification (ID)	2,008,378	100%†	2,006,994	99.93%

Table 2. Completeness and Accuracy Rates—Claim Lines Submitted by Simply Healthcare				
Field	**Present**	**Completeness Rate**	**Accurate**	**Accuracy Rate***
Plan ID	2,008,430	100%	2,008,430	100%
Claim Reference Number	2,008,430	100%	2,008,430	100%
Billing Date	2,008,428	100%†	2,008,428	100%
Claim Paid Date	2,008,430	100%	2,008,430	100%
Admit Date**	280,139	100%	280,139	100%
Diagnosis Code	2,007,687	99.96%	2,001,600	99.70%
Procedure Code	1,965,903	97.88%	1,916,804	97.50%
First Date of Service	2,008,430	100%	2,008,430	100%
Last Date of Service	2,008,430	100%	2,008,430	100%
Units of Service	2,008,430	100%	2,008,430	100%
Total Days	2,008,430	100%	2,008,430	100%
Financial Report Service Category	2,008,430	100%	2,008,430	100%
Treating Provider Type	2,007,045	99.93%	2,006,548	99.98%
Treating Provider National Provider Identifier (NPI)	2,007,324	99.94%	2,007,313	100%†
Treating Provider Medicaid ID	2,004,481	99.80%	2,003,979	99.97%
Treating Provider Specialty Code	2,005,526	99.86%	2,005,026	99.98%
Billing Provider Type	2,006,050	99.88%	2,005,578	99.98%
Billing Provider NPI	2,006,869	99.92%	2,006,775	100%†
Billing Provider Medicaid ID	1,983,897	98.78%	1,983,425	99.98%
Billing Provider Specialty Code	2,004,281	99.79%	2,003,681	99.97%
Facility Provider Type**	279,732	99.85%	279,732	100%
Facility Provider NPI**	279,732	99.85%	279,732	100%
Facility Provider Medicaid ID**	279,657	99.83%	279,657	100%
Place of Service††	1,728,291	100%	1,728,290	100%†

** 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

Completion and accuracy rates for all key claim data fields were over 97.5%.

Table 3 displays completeness and accuracy rates for key encounter data fields for Simply Healthcare.

Table 3. Completeness and Accuracy Rates—Encounter Lines Submitted by Simply Healthcare				
Field	**Present**	**Completeness Rate**	**Accurate**	**Accuracy Rate***
	N=74,768			
Member Identification (ID)	74,761	99.99%	74,761	100%
Plan ID	74,768	100%	74,768	100%
Claim Reference Number	74,768	100%	74,768	100%
Billing Date	74,768	100%	74,768	100%
Claim Paid Date	74,768	100%	74,768	100%
Diagnosis Code	74,768	100%	74,698	99.91%
Procedure Code	74,768	100%	74,697	99.91%
First Date of Service	74,768	100%	74,768	100%
Last Date of Service	74,768	100%	74,768	100%
Units of Service	74,768	100%	74,768	100%
Total Days	74,768	100%	74,768	100%
Financial Report Service Category	74,768	100%	74,768	100%
Treating Provider Type	74,768	100%	74,768	100%
Treating Provider National Provider Identifier (NPI)	74,768	100%	74,768	100%
Treating Provider Medicaid ID	74,324	99.41%	74,324	100%
Treating Provider Specialty Code	74,768	100%	74,768	100%
Billing Provider Type	74,768	100%	74,768	100%
Billing Provider NPI	74,768	100%	74,767	100%†
Billing Provider Medicaid ID	71,965	96.25%	71,965	100%
Billing Provider Specialty Code	74,768	100%	74,768	100%
Place of Service	74,768	100%	74,768	100%

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

Completion and accuracy rates for all key encounter data fields were above 96.2%.

Table 4 displays completeness and accuracy rates for key pharmacy data fields for Simply Healthcare.

Table 4. Completeness and Accuracy Rates—Pharmacy Lines Submitted by Simply Healthcare				
Field	**Present**	**Completeness Rate**	**Accurate**	**Accuracy Rate***
	N=710,779			
Member Identification (ID)	710,094	99.90%	710,075	100%†
Plan ID	710,779	100%	710,779	100%
Claim Reference Number	710,779	100%	710,779	100%
Billing Date	710,779	100%	710,779	100%
Claim Paid Date	710,779	100%	710,779	100%
First Date of Service	710,779	100%	710,779	100%
Units of Service	710,779	100%	710,779	100%
Financial Report Service Category	710,779	100%	710,779	100%
Treating Provider Type	709,501	99.82%	709,501	100%
Treating Provider National Provider Identifier (NPI)	710,779	100%	710,768	100%†
Treating Provider Medicaid ID	709,501	99.82%	709,481	100%†
Treating Provider Specialty Code	709,501	99.82%	709,498	100%†
Billing Provider Type	710,779	100%	710,779	100%
Billing Provider NPI	710,779	100%	710,779	100%
Billing Provider Medicaid ID	708,644	99.70%	708,644	100%
Billing Provider Specialty Code	710,779	100%	710,779	100%
National Drug Code (NDC)	625,458	**88.00%**	625,458	100%
Class	625,453	**88.00%**	625,453	100%
Primary Pharmacy ID	626,712	**88.17%**	626,701	100%†
Days' Supply	626,712	**88.17%**	626,712	100%

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

Completeness rates for key pharmacy data fields were over 99.7%, with the exception of NDC and Class, both at 88.0%, and Primary Pharmacy ID and Days' Supply, both at 88.2%. Accuracy rates for all key pharmacy data fields were 99.9% or higher.

Medical Record Review for Validation of Encounter Data

Table 5 summarizes the medical records requested and received for physician encounters from Simply Healthcare, including the medical records reviewed by provider specialty.

Table 5. Medical Records by Provider Specialty	
Medical Records Requested	122
Medical Records Unavailable	1
Medical Records Reviewed – Total	**121**
Medical Records Reviewed – Dermatology	121

All of the encounters identified for this review were associated with specialty care physicians. It was expected that the majority of these encounters would have been for primary care physicians, as they are more typically associated with capitated payment arrangements. Further analysis of total encounters submitted demonstrated that Simply Healthcare's physician encounters were related to capitated vendor arrangements (sub-capitation).

Table 6 summarizes validation results for the medical record review, including validation of Performing Provider NPI, date of service, all CPT procedure codes, and the first three primary ICD-10 diagnosis codes on each encounter record. For the procedure and diagnosis code validation, Qsource addressed the following:

- Were all the procedure/diagnosis codes in the electronic record documented in the medical record and all procedures/diagnoses documented in the medical record coded in the electronic record (Correctly Coded)?
- Were there procedure/diagnosis codes in the electronic record that were not documented in the medical record (Undocumented Codes)?
- Were there procedures/diagnoses documented in the medical record that were not coded in the electronic record (Missing Codes)?

The acceptable error rate is considered to be 5%, so any accuracy rate less than 95% is presented in bold red text.

Table 6. Medical Record Review Results		
Data Field	**Accuracy**	
	#	**%**
Performing Provider National Provider Identifier (NPI)	107	**88.43%**
Date of Service	121	100%
Current Procedural Terminology (CPT) Procedure Codes		
Correctly Coded	121	100%
Undocumented Codes	0	0%*

Table 6. Medical Record Review Results		
Data Field	**Accuracy**	
	#	**%**
Missing Codes	0	0%*
International Classification of Diseases (ICD-10) Diagnosis Codes		
Correctly Coded	116	95.87%
Undocumented Codes	6	4.96%*
Missing Codes	3	2.48%*

** These figures represent the percentage of encounter records with undocumented or missing codes (CPT Procedure Codes and ICD-10 Diagnosis Codes) and are considered error rates rather than accuracy rates. Thus, a lower percentage in these categories is favorable.*

Performing Provider NPI was matched to performing provider on the medical record in 88.4% of the 121 records reviewed. The lower rate was primarily the result of illegible provider signatures in the medical record. Date of service was consistent in the electronic record and the medical record in 100% of the cases. Procedure codes were consistently coded in 100% of cases. Diagnosis codes were consistently coded in 95.9% of cases.

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 7**, 8, 9, 10, and 11. The acceptable potential error rate is considered to be 5%, so any potential error rate above 5% is presented in bold red text.

Table 7 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 Simply Healthcare, 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 7. Duplicated Payment	
Duplicate Claims/Encounters Reported	15,327
Total Duplicate Claims/Encounters Paid	3,091
Potential Error Rate	**20.17%**
Paid Duplicates as % of Total Claims/Encounters	**0.25%**

More than 15,000 duplicate claims and encounters were identified with the majority of these indicated as denied. This resulted in a potential error rate of 20.2%. However, detailed analysis demonstrated that 2,918 of the 3,091 claims/encounters reported as paid actually had 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 173 duplicate claims/encounters were coded as paid, reducing the potential error rate to 0.1%. All duplicate claims and encounters coded as paid accounted for a negligible percentage of total claims and encounters submitted (0.3%).

Table 8 displays services for which enrollees were not eligible on the date of service, total number of these service paid, potential error rate, and ineligible services paid as a percentage of total claims and encounters for Simply Healthcare.

Table 8. Eligibility on Date of Service	
Total Services for Which Enrollee Not Eligible on Date of Service	13,883
Ineligible Services Paid	1,600
Potential Error Rate	**11.52%**
Paid Ineligible Services as % of Total Claims	**0.13%**

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. Over 13,000 claims/encounters were submitted for ineligible dates of service. Of these, 1,600 had a paid status, resulting in a potential error rate of 11.5%. However, almost one-third of the paid claims/encounters had a header paid amount less than or equal to zero, indicating they may actually have been denied. Removing these from the analysis, the potential error rate dropped to 7.0%. Paid claims/encounters for ineligible enrollees accounted for a negligible percentage of total claims/encounters submitted, representing only 0.1%.

Table 9 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 Simply Healthcare. 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 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	79,055	6,218	**7.87%**	**0.51%**
PCP Well-Child Care	5,788	312	**5.39%**	**0.03%**
PCP Immunizations	42,497	4,552	**10.71%**	**0.37%**
PCP Routine Vision Screening	17,485	4,385	**25.08%**	**0.36%**
PCP Routine Hearing Screening	22,485	5,348	**23.78%**	**0.44%**
Specialist Office Visit	133,251	9,575	**7.19%**	**0.78%**
Chiropractor	1,041	627	**60.23%**	**0.05%**
Podiatrist	2,524	522	**20.68%**	**0.04%**
Diagnostic Testing	134,526	27,516	**20.45%**	**2.25%**
Outpatient Behavioral Health and Substance Abuse Treatment	20,754	1,241	**5.98%**	**0.10%**
Inpatient Services (including behavioral health and substance abuse services)	11,548	811	**7.02%**	**0.07%**
Inpatient Hospital or Nursing Facility for Rehabilitation or Physical Therapy	†	†	†	†
Maternity Care – Mother	†	†	†	†
Family Planning Visit	192	7	3.65%	**0%**
Emergency Room	46,538	1,768	3.80%	**0.14%**
Emergency Transportation	488	37	**7.58%**	**0%**
Urgent Care Center	17,817	2,768	**15.54%**	**0.23%**
Home Health	†	†	†	†
Hospice	†	†	†	†
Refraction – Optometrist	5,207	379	**7.28%**	**0.03%**
Corrective Lenses and Frames	9,113	381	4.18%	**0.03%**
Durable Medical Equipment	5,029	1,076	**21.40%**	**0.09%**
Nursing Facility	687	0	0%	**0%**

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

For 4 of the 23 service categories, less than 100 services were reported and were not included in the analysis. Across the remaining 19 service categories, approximately 87.9% of services within benefit scope and limitations were reported as paid (488,502 out of 556,025 total services). For the majority of these categories, the potential error rate exceeded the 5% standard: Primary Care Provider (PCP) Office Visit, 7.9%; PCP Well-Child Care, 5.4%; PCP Immunizations, 10.7%; PCP Routine Vision Screening, 25.1%; PCP Routine Hearing Screening, 23.8%; Specialist Office Visit, 7.2%; Chiropractor, 60.2%; Podiatrist, 20.7%; Diagnostic Testing, 20.5%; Outpatient Behavioral Health and Substance Abuse Treatment, 6.0%; Inpatient Services, 7.0%; Emergency Transportation, 7.6%; Urgent Care Center, 15.5%; Refraction – Optometrist, 7.3%; and Durable Medical Equipment, 21.4%. Potential error rates among remaining categories ranged from 0% to 4.2%. 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. For services within benefit scope and benefit limitations not paid as a percentage of total claims and encounters, all categories were under 0.8% except Diagnostic Testing (2.3%).

Table 10 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 Simply Healthcare. 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 10. 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*	9,142	451	4.93%	**0.04%**
Inpatient Stays for Rehabilitation and Physical Therapy – 15 Days per Calendar Year	†	†	†	†
Chiropractic Services – One Visit per Day	251	1	0.40%	**0%**
Chiropractic Services – 24 Visits per Calendar Year	†	†	†	†
Podiatric Services – One Visit per Day	†	†	†	†
Podiatric Services – Two Visits per Month	114	37	**32.46%**	**0%**
Family Planning Services – One Visit Every 90 Calendar Days	†	†	†	†

Table 10. 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**
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 five of the eight benefit categories, the number of services reported over benefit limitations was low (less than 100). For the remaining three categories, the potential error rate was within the acceptable 5% standard except for Podiatric Services – Two Visits per Month, at 32.5%. However, the potential error rate was high due to the small number of applicable claims and encounters; only 37 claims/encounters over limitations were coded as paid.

Table 11 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 11. 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	100,194	25,644	**25.59%**	**NA**
Primary Care Provider Visits* (excluding well-child care, preventive visits, immunizations, routine hearing and vision screening) – $5 per Visit	28,345	2,601	**9.18%**	**0.21%**
Specialist Office Visits – $5 per Visit	108,830	73,559	**67.59%**	**6.02%**
Chiropractic Visits – $5 per Visit	314	71	**22.61%**	**0.01%**
Podiatric Visits – $5 per Visit	1,896	1,255	**66.19%**	**0.10%**
Emergency Room Services* – $10 per Visit, Waived if Admitted	1,295	30	2.32%	**0%**
Vision Services – $5 per Visit	4,776	3,608	**75.54%**	**0.30%**

Table 11. 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**
Corrective Lenses – $10 per Item	7,312	7,312	**100%**	**0.60%**
Behavioral Health/Substance Abuse Disorder Specialist Visits* – $5 per Visit	2,830	1,028	**36.33%**	**0.08%**
Physical Therapy – $5 per Visit	14,700	11,642	**79.20%**	**0.95%**
Occupational Therapy – $5 per Visit	14,700	11,633	**79.14%**	**0.95%**
Respiratory Therapy – $5 per Visit	1,298	486	**37.44%**	**0.04%**
Speech Therapy – $5 per Visit	10,673	10,081	**94.45%**	**0.82%**

** COVID-19 relief efforts waived applicable copays from April through December 2020.*

Across all service categories except one, Emergency Room Services (2.3%), 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. Also for all categories, the percentage of total claims and encounters was negligible (less than 1.0%) except Specialist Office Visits, at 6.0%.

Summary of Data Submission Issues Observed

In completing this analysis, a significant number of fee-for-service claims coded as paid with a 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 13).

Table 12 includes Simply Healthcare'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 12. 2020 Program Integrity Compliance Standard Score	
Simply Healthcare	86.8%

Simply Healthcare's documentation was compliant for all but four criteria from all 12 elements in the evaluation tool, resulting in an overall score of 86.8%.

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 13 summarizes the strengths, suggestions, and AONs for Simply Healthcare.

Table 13. Strengths, Suggestions, and Areas of Noncompliance	
Strengths	
Element 1: Fraud, Waste, and Abuse Procedure Components – 1	The Florida Compliance Plan was Florida specific.
Element 2: Fraud, Waste, and Abuse Procedure Components – 2	Both the Compliance Plan and SIU [Special Investigations Unit] Antifraud Plan thoroughly addressed components of appropriate fraud, waste, and abuse procedures.
Element 3: Fraud, Waste, and Abuse Procedure Components – 3	The SIU Antifraud Plan included a detailed Florida-specific addendum.
Element 6: Fraud, Waste, and Abuse Procedure Components – 6	The SIU Antifraud Plan included a comprehensive description of SIU staffing, resources, and caseload expectations.
Suggestions	
Element 3: Fraud, Waste, and Abuse Procedure Components – 3	The managed care organization (MCO) could update the SIU Antifraud Plan to include notification to Florida Healthy Kids Corporation (FHKC) of changes in provider circumstances that may affect the network provider's eligibility to participate in the program.
Element 5: Fraud, Waste, and Abuse Procedure Components – 5	The MCO could update the SIU Antifraud Plan to include prompt reporting to FHKC of information indicating fraud or potential fraud by a provider, subcontractor, applicant, or enrollee.
Element 9: Disclosures	The MCO could update Policy and Procedure: Premium Discrepancy Report/Resolution Process to indicate 60 calendar days for notification to FHKC of excess payments.

Table 13. Strengths, Suggestions, and Areas of Noncompliance	
AONs	
Element 3: Fraud, Waste, and Abuse Procedure Components – 3	The MCO should document the requirement to notify FHKC of changes in enrollee circumstances that could affect the enrollee's eligibility.
Element 4: Fraud, Waste, and Abuse Procedure Components – 4	The MCO should update the Payment Withhold and Suspensions Processing Instructions to include the provision for suspension of payments to providers for which FHKC determines there is a credible allegation of fraud.
Element 9: Disclosures	While Policy: Disclosure of Ownership addressed written disclosures of information on ownership and control, it was not effective for the entire review period.
Element 10: Treatment of Recoveries	The MCO should update the provider manual to include that overpayments must be returned within 60 calendar days of identification.

Four strengths were identified for Simply Healthcare, related to the Florida-specific Compliance Plan and addendum for the Anti-Fraud Plan and detailed documentation of Special Investigations Unit staffing, resources, and caseload expectations. Four AONs were identified. Three involved lack of documentation supporting CFR requirements, including notifying FHKC of changes in enrollee circumstances documenting suspension of payments to providers for which FHKC determines there is a credible allegation of fraud, and requiring providers to report overpayments within 60 calendar days of identification. The last AON related to disclosures of ownership, which was addressed in a policy that went into effect later in the review period. While Simply Healthcare demonstrated compliance in operational practice, three suggestions were made to document notification to FHKC of changes in provider circumstances, prompt reporting to FHKC of fraud or potential fraud, and notification to FHKC within 60 calendar days of excess capitation or other payments.

Further assessment of program integrity processes in the MCO's operational practice is presented in **tables 14**, 15, 16, and 17.

Table 14. Prospective Claim System Edits	
National Correct Coding Initiative (NCCI)	Code Editing Testing Form demonstrated quarterly testing of all components of NCCI edits. Appendix A: Program Integrity Documentation Requirements described the process of obtaining NCCI files and transferring the files to Change Health Care (CHC) via the Workspace Tool. CHC then loaded the data files to the next ClaimsXten release, which proceeded into the test environments. Finally, changes were deployed to production and tested.
Other	Enterprise Provider Education – Program Outline described Enterprise Provider Education, an area within Program Integrity, which supported coding as laid forth by the Centers for Medicare & Medicaid Services and the American Medical Association coding guidelines. The base prospective edit set was provided, including a comprehensive set of categorical edits.

Simply Healthcare 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 15. Retrospective Processes for Claim Screening	
Standard Reporting and Screening Processes	SIU [Special Investigations Unit] Operational Policy and Procedure #034MCD: SIU Data Mining described the data-mining process for potential fraud, waste, or abuse. An outside vendor was used to analyze and score claims data to generate potential fraud, waste, and abuse leads.
Specific Investigation Processes	The managed care organization's SIU maintained over 30 standard quarterly reports on known areas of concern, which were issued to all SIU investigators and the data-mining team for monitoring and case leads.
Sample Screening Reports	A detailed claim screening report for identification of potential fraud, waste, or abuse was provided.

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

Table 16. Follow-Up Processes	
Standard Follow-Up Processes	Policy and Procedure: Investigations of Suspected Fraud and Abuse included a description of resolutions, which could include sending a warning letter to the provider, prepayment review, recommending suspension or termination of the provider, seeking recovery of payments from the provider, imposing sanctions, and/or actions as directed by the State contract.
Sample Follow-Up Activities Conducted	A sample provider education letter with detailed coding and documentation instructions was provided.

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

Table 17. Claims System Flagging for Nonpayment	
Federal and State Excluded Providers	Ineligible Provider Report Processing Instructions detailed the processes by which providers in the production system were identified and flagged as ineligible. Payment Withhold and Suspensions Processing Instructions also described processes by which payment suspensions and withholds were put in place.

Simply Healthcare 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 four data fields. Accuracy rates were all 100%. Results of the medical record review conducted for Simply Healthcare demonstrated that date of service, procedure coding, and diagnosis coding were highly consistent between the electronic and medical records while performing provider identification was less consistent.

Qsource derives from the accuracy of benefit application analyses that determination of accurate payment 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 Simply Healthcare, with a total score of 86.8%, demonstrated a moderate level of compliance for the truthfulness of claim and encounter data based on documentation of program integrity requirements.

MCO Recommendations

Qsource recommends the actions in **Table 18** for Simply Healthcare.

Table 18. Qsource Recommendations for Simply Healthcare

Category	Data Field(s) / Service(s)	Issue	Recommendation
Completeness of Key Pharmacy Data Fields	♦ National Drug Code (NDC) ♦ Class ♦ Primary Pharmacy Identification (ID) ♦ Days' Supply	The completeness rate was below the acceptable rate of 95%.	Ensure completeness 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) Office Visit ♦ PCP Well-Child Care ♦ PCP Immunizations ♦ PCP Routine Vision Screening ♦ PCP Routine Hearing Screening ♦ Specialist Office 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.

Table 18. Qsource Recommendations for Simply Healthcare

Category	Data Field(s) / Service(s)	Issue	Recommendation
	♦ Chiropractor ♦ Podiatrist ♦ Diagnostic Testing ♦ Outpatient Behavioral Health and Substance Abuse Treatment ♦ Inpatient Services (including behavioral health and substance abuse services)		
Services Over Limitation by Service Category	Podiatric Services – Two Visits per Month	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 for Which Copays Applied by Service Category	♦ Prescription Drugs – $5 per Prescription ♦ PCP Visits (excluding well-child care, preventive visits, immunizations, routine hearing and vision screening) – $5 per Visit ♦ Specialist Office Visits – $5 per Visit ♦ Chiropractic Visits – $5 per Visit ♦ Podiatric Visits – $5 per Visit ♦ 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	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 18. Qsource Recommendations for Simply Healthcare			
Category	**Data Field(s) / Service(s)**	**Issue**	**Recommendation**
	♦ Respiratory Therapy – $5 per Visit ♦ Speech Therapy – $5 per Visit		
Data Submission Issues Observed	Claim Line Status Paid at Header	Fee-for-service claims with header status of "P" but a 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 Florida Compliance Plan (Compliance Plan) did not clearly document compliance with Florida Healthy Kids Corporation (FHKC) contractual obligations.	The managed care organization (MCO) could update the Compliance Plan to explicitly address FHKC contractual requirements in its policies and procedures.
Truthfulness of Claim and Encounter Data	Fraud, Waste, and Abuse Procedure Components	The Compliance Plan did not specifically state standards under the FHKC contract.	The MCO could update the Compliance Plan to explicitly address the Compliance Officer's responsibility to ensure compliance under the FHKC contract.
Truthfulness of Claim and Encounter Data	Fraud, Waste, and Abuse Procedure Components	The Compliance Plan did not explicitly address compliance with FHKC contract requirements and standards.	The MCO could update the Compliance Plan to explicitly address the Compliance Committee's responsibility to ensure compliance under the FHKC contract.
Truthfulness of Claim and Encounter Data	Fraud, Waste, and Abuse Procedure Components	The Compliance Plan did not specifically state standards under the FHKC contract.	The MCO could update the Compliance Plan to explicitly address compliance with the FHKC contract in the training and education program.
Truthfulness of Claim and Encounter Data	Fraud, Waste, and Abuse Procedure Components	No documentation of the requirement to notify FHKC of changes in enrollee circumstances was provided.	The MCO should document the requirement to notify FHKC of changes in enrollee circumstances that could affect the enrollee's eligibility.
Truthfulness of Claim and Encounter Data	Fraud, Waste, and Abuse Procedure Components	The Special Investigations Unit (SIU) Antifraud Plan described the prompt disclosure to the Medicaid Program	The MCO could update the SIU Antifraud Plan to include notification to FHKC of changes in provider circumstances that may affect the network provider's

Table 18. Qsource Recommendations for Simply Healthcare			
Category	**Data Field(s) / Service(s)**	**Issue**	**Recommendation**
		Integrity (MPI) Unit of changes in provider circumstances, but did not address notification to FHKC.	eligibility to participate in the program.
Truthfulness of Claim and Encounter Data	Fraud, Waste, and Abuse Procedure Components	The Payment Withhold and Suspensions Processing Instructions did not address notifications for suspension of payments for network providers from FHKC.	The MCO should update the Payment Withhold and Suspensions Processing Instructions to include the provision for suspension of payments to providers for which FHKC determines there is a credible allegation of fraud.
Truthfulness of Claim and Encounter Data	Fraud, Waste, and Abuse Procedure Components	The SIU Antifraud Plan addressed prompt reporting to the MPI Unit, but did not address notification to FHKC specifically.	The MCO could update the SIU Antifraud Plan to include prompt reporting to FHKC of information indicating fraud or potential fraud by a provider, subcontractor, applicant, or enrollee.
Truthfulness of Claim and Encounter Data	Disclosures	The policy was not effective for the entire year in review.	While Policy: Disclosure of Ownership addressed written disclosures of information on ownership and control, it was not effective for the entire review period.
Truthfulness of Claim and Encounter Data	Disclosures	Policy and Procedure (P&P): Premium Discrepancy Report/Resolution Process did not indicate calendar days.	The MCO could update P&P: Premium Discrepancy Report/Resolution Process to indicate 60 calendar days for notification to FHKC of excess payments.
Truthfulness of Claim and Encounter Data	Treatment of Recoveries	The provider manual did not address that overpayments must be returned within 60 calendar days of identification.	The MCO should update the provider manual to include that overpayments must be returned within 60 calendar days of identification.

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 | Simply Healthcare Program Integrity Standard Tool

2021 Periodic Audit: Simply Healthcare Plans (Simply Healthcare)					
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**	**1.000**

2021 Periodic Audit: Simply Healthcare Plans (Simply Healthcare)					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Findings	The Florida Compliance Plan (Compliance Plan) included detailed references to policies and procedures that complied with all applicable state and federal law, the MCO's contractual obligations with the Agency for Healthcare Administration (AHCA), and the Code of Conduct. However, compliance with Florida Healthy Kids Corporation (FHKC) contractual obligations was not clearly documented. The Compliance Plan addressed the Compliance Officer, with the primary responsibility of developing, operating, overseeing, and monitoring the implementation of the Compliance Plan. The Compliance Plan noted that the Compliance Officer reported to the Chief Executive Officer (CEO), the board of directors, and the Compliance Committee. However, compliance with FHKC contract requirements and standards was not explicitly stated. The Compliance Plan described the Compliance Committee, which reported to the board of directors, included senior management representation, and had the responsibility of oversight of the Compliance Plan. The implementation, administration, and oversight of the compliance program was noted to be delegated to the Plan Compliance Officer and the Florida Compliance Committee. However, standards under the contract were not specifically stated. The Compliance Plan included a detailed description of the training and education program for employees, subcontractors, and the board of directors on federal and state standards. However, standards under the contract were not specifically stated.				
Strength	The Florida Compliance Plan was Florida-specific.				
AON	None were identified.				
Suggestion	1. The MCO could update the Compliance Plan to explicitly address FHKC contractual requirements in its policies and procedures. 2. The MCO could update the Compliance Plan to explicitly address the Compliance Officer's responsibility to ensure compliance under the FHKC contract. 3. The MCO could update the Compliance Plan to explicitly address the Compliance Committee's responsibility to ensure compliance under the FHKC contract. 4. The MCO could update the Compliance Plan to explicitly address compliance with the FHKC contract in the training and education program.				
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: Simply Healthcare Plans (Simply Healthcare)					
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 included a detailed description of effective and appropriate lines of communication among the Compliance Officer, employees, contractors, agents, directors, and the Compliance Committee. Methods by which disciplinary guidelines were publicized and enforced were presented. The Compliance Plan clearly indicated that the MCO prohibited retaliation against any employee for making a good faith report of potential noncompliance. The Compliance Plan and the Special Investigations Unit (SIU) Antifraud Plan provided a comprehensive description of the procedures and system for monitoring and auditing compliance risks, prompt response to issues, investigation of potential compliance problems, and correction of such problems.

Strength Both the Compliance Plan and SIU Antifraud Plan thoroughly addressed components of appropriate fraud, waste, and abuse procedures.

AON None were identified.

Suggestion None were identified.

2021 Periodic Audit: Simply Healthcare Plans (Simply Healthcare)					
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**	**0.750**

2021 Periodic Audit: Simply Healthcare Plans (Simply Healthcare)					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Findings	No documentation of the requirement to notify FHKC of changes in enrollee circumstances was provided. The SIU Antifraud Plan described the prompt disclosure to the Medicaid Program Integrity (MPI) Unit of changes in provider circumstances, but did not address notification to FHKC. A Florida Healthy Kids Network Add/Term Report demonstrated notification to FHKC of changes in provider circumstances. The SIU Antifraud Plan included the process by which a sample of enrollees received copies of the explanation of medical benefits for claims paid in the prior month and enrollees were instructed to call the Call Center to report any services they did not receive. The SIU Antifraud Plan included the *False Claims Act* as a component of employee fraud, waste, and abuse training and the education of employees about the whistleblower protections under federal and state law.				
Strength	The SIU Antifraud Plan included a detailed Florida-specific addendum.				
AON	The MCO should document the requirement to notify FHKC of changes in enrollee circumstances that could affect the enrollee's eligibility.				
Suggestion	The MCO could update the SIU Antifraud Plan to include notification to FHKC of changes in provider circumstances that may affect the network provider's eligibility to participate in the program.				
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 SIU Antifraud Plan included the provision for reporting of potential fraud, waste, or abuse to the MPI Unit. The Payment Withhold and Suspensions Processing Instructions included reference to AHCA suspension notifications and the operational process by which payments were suspended for these providers. However, notifications for suspension of payments for network providers from FHKC were not addressed.				
Strength	None were identified.				

2021 Periodic Audit: Simply Healthcare Plans (Simply Healthcare)					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
AON	The MCO should update the Payment Withhold and Suspensions Processing Instructions to include the provision for suspension of payments to providers for which FHKC determines there is 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 SIU Antifraud Plan addressed prompt reporting to the MPI Unit, but did not address notification to FHKC specifically. The Florida Healthy Kids Fraud and Abuse Report Quarter 3, 2020 demonstrated notification to FHKC of fraud or potential fraud.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	The MCO could update the SIU Antifraud Plan to include prompt reporting to FHKC of information indicating fraud or potential fraud by a provider, subcontractor, applicant, or enrollee.				
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 SIU Antifraud Plan addressed detailed staffing and resource allocation to the Florida SIU.				
Strength	The SIU Antifraud Plan included a comprehensive description of SIU staffing, resources, and caseload expectations.				
AON	None were identified.				
Suggestion	None were identified.				

2021 Periodic Audit: Simply Healthcare Plans (Simply Healthcare)					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
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 SIU Antifraud Plan included the cooperation in any investigation and subsequent legal action that may result as a component of the antifraud plan.				
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 FL: Additional State Specific Regulatory or Contractual Requirements for Florida included the requirement that all providers have a unique active Florida Medicaid provider number.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				

2021 Periodic Audit: Simply Healthcare Plans (Simply Healthcare)					
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	Policy #EP302: OIG/GSA Screening Policy addressed disclosure of prohibited affiliations under 42 CFR 438.610. Policy: Disclosure of Ownership addressed written disclosures of information on ownership and control required under 42 CFR 455.104. However, the policy indicated that it would be enforced beginning 9/1/20. Policy and Procedure (P&P): Premium Discrepancy Report/Resolution Process provided for the reporting to FHKC of capitation or other payments in excess of the amount specified in the contract within 60 days of identification. However, it did not indicate “calendar days.” Premium Reconciliation ePAS Process addressed the 60-calendar-day requirement.
Strength	None were identified.
AON	While Policy: Disclosure of Ownership addressed written disclosures of information on ownership and control, it was not effective for the entire review period.
Suggestion	The MCO could update P&P: Premium Discrepancy Report/Resolution Process to indicate 60 calendar days for notification to FHKC of excess payments.

2021 Periodic Audit: Simply Healthcare Plans (Simply Healthcare)					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
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**
Findings	The provider manual included instructions for reporting overpayments, including the requirement to report the reason for the overpayment. However, it did not address that overpayments must be returned within 60 calendar days of identification. The 2020 Annual Overpayment to Providers Report showed provider overpayments identified and recovered.				
Strength	None were identified.				
AON	The MCO should update the provider manual to include that overpayments must be returned within 60 calendar days of identification.				
Suggestion	None were identified.				
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	☑ 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	**0.500** **0.500**	**1.000**	**1.000**

2021 Periodic Audit: Simply Healthcare Plans (Simply Healthcare)					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
	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)	☐ Not Applicable	**0.000**		
	Findings	Policy #EP302 addressed screening of parties through the General Services Administration System for Award Management to verify the party and any affiliates were not excluded from participating in procurement activities under the Federal Acquisition Regulation.			
	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	Policy #EP302 included provisions for screening individuals and entities for exclusion from participation in federally funded healthcare programs.			
	Strength	None were identified.			
	AON	None were identified.			
	Suggestion	None were identified.			

2021 Periodic Audit: Simply Healthcare Plans (Simply Healthcare)					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Program Integrity					
Program Integrity for Periodic Audit			**86.8%**	**12.000**	**10.417**

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.

Simply Healthcare Plans, Inc. provided its responses within the report. Qsource extracted the responses and aggregated them below:

Table 4 Plan Response:

PLAN RESPONSE: The deficiency in the key pharmacy fields noted is due to the nature in which a certain group of claims are coded in the encounter data. An expanded benefit offered by Simply to cover over the counter (OTC) benefits is coded with Claim Type "P" (denoting pharmacy claims) and Financial Report Service Category M10.1 (Expanded Benefit FFS),. However, these OTC claims do not contain all the information that prescription drug claims do. If OTC claims are not considered in the pharmacy claims distribution, these 4 fields are above 99% completeness rate as well.

Table 6 Plan Response:

PLAN RESPONSE: Health plan does require all of participating providers to have an NPI number. The lower rate is possibly a result of illegible provider signatures in the medical record.

Table 7 Plan Response:

PLAN RESPONSE: The plan reviewed the duplicate payment encounters and examples provided by QSource. Our findings are included below.

Out of the 10 claim examples:

- 3 claims were indeed duplicate claims paid, however, the plan had already identified the duplicate payment and adjusted/recovered accordingly.
- 2 claims paid correctly and were not duplicate payments. In these examples, the provider submitted one claim with multiple Dates of service and payments were made under the same claim for the multiple DOS.
- There were 2 claims where the plan's BH vendor provided duplicate payments. The plan is working with vendor to identify cause and remediation.
- 3 claims were paid correctly.

Table 8 Plan Response:

PLAN RESPONSE: The plan reviewed the encounters and examples provided by QSource. Our findings are included below.

Out of the 10 claim examples:

• 5 Medicaid claims were incorrectly included in the data. These claims should not have been included.
• 1 claim was correctly processed after receiving a member reinstatement request from the FHK resolve inbox.
• 1 claim was correctly processed according to member's eligibility.
• 3 claims were indeed paid incorrectly (2 were a result of a processing error, specific claim remediation/recoup in process) and (1 was an analyst error).

Table 9 Plan Response:

PLAN RESPONSE: Based on the claim samples provided to the plan,

1. We found that most of the claims were processed correctly and denied/not paid due to the provider being non-participating, no authorization on file, or were duplicate submissions.
2. There was a low volume of claims that were processed incorrectly, the plan will correct and reprocess the claims accordingly. Incorrect denials were a result of Claim's Analyst processing errors.
3. Timing issue -there were some original claims that had been denied, however, the claims have already been adjusted to pay.

Table 10 Plan Response:

PLAN RESPONSE: The current plan configuration inadvertently excluded the benefit limitation on some of the podiatry related codes. We are currently updating the configuration.

Table 11 Plan Response:

PLAN RESPONSE: Based on the claim samples provided to the plan,

Prescription Drugs –$5 per Prescription

Zero co-pay reasons:

1. Some antibiotics are free at Publix, since these are free, we do not ask the member to pay the $5 copay because we would be charging the member more for their co-pay than the actual cost of the prescription, this is called lessor of logic. Overall, anytime the cost of the drug is less than the $5 co-pay our system will align with the cost, that way we are not charging members a higher co-pay than the actual price of the medication.
2. EF (emergency fill) –This is a CMS rule, if a member needs an emergency fill, they are entitled to a 3 day supply of medication. We do not charge co-pays for an emergency fill since it's just a temporary mediation supply.
3. COB (coordination of benefits) –FHK must be the payer of last resort. One of the claims the members primary insurance paid (Commercial UHC) and there was no co-pay because FHK didn't pay anything for this claim (primary insurance paid for all).
4. Members part of the Subsidized no co-pay plan so there is $0 co-pay.
5. Similar to the findings in Table 4, the categorization of OTC claims are the main reason for the high number of claims for which copay services were not applied. If the OTC claims are removed from the Prescription Drugs category, the remaining pharmacy claims have a low potential error rate with regards to copays applied.

Primary Care Provider Visits* (excluding well-child care, preventive visits, immunizations, routine hearing and vision screening) –$5 per Visit

A review of the claims where no-copays were applied identified the following:

- Services were rendered during the period of time a COVID-19 Waiver was in effect
- Some of the PCP visits were for services where co-pays do not apply

Specialist Office Visits –$5 per Visit

A review of the claims where no-copays were applied identified the following:

- Services were rendered during the period of time a COVID-19 Waiver was in effect
- Some of the visits were for services where co-pays do not apply

Chiropractic Visits –$5 per Visit

A review of the claims where no-copays were applied identified the following:

- Services were rendered during the period of time a COVID-19 Waiver was in effect
- Some of the visits were for services where co-pays do not apply

Podiatric Visits –$5 per Visit

The current plan podiatry benefit configuration inadvertently excluded copays from some podiatry codes. We are currently updating the configuration.

Vision Services –$5 per Visit

The plan reviewed the vision encounters and examples provided by QSource. Our findings are as follows:

- Vision claims processed by the plan did not apply the co-pays as required.
- Some of the vision benefit configuration inadvertently excluded copays from some vision codes. The plan is updating the configuration.
- Plan is updating configuration to reflect that vision claims are to be processed and paid by vision vendor.

Table 11 Plan Response:

(1) Corrective Lenses –$10 per Item

The plan reviewed the vision encounters and examples provided by QSource related to corrective lenses. Our findings are as follows:

- Plan's prior vision vendor, EyeQuest, failed to correctly apply co-pays for corrective lenses.
- Current vendor, iCare, is applying co-pays correctly.

(2) Behavioral Health/Substance Abuse Disorder Specialist Visits* –$5 per Visit

The plan reviewed the BHencounters and examples provided by QSource. Our findings are as follows:

- The plan's behavior health vendor is correctly collecting co-pays. The failure to report co-pays is a result ofa reporting logic issue.
- The plan is working with Beacon, BH vendor, to correct reporting logic

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(3) Physical Therapy –$5 per Visit

The plan reviewed the therapy encounters and examples provided by QSource. Our findings are as follows:

- The plan's therapy vendor is correctly collecting co-pays. The failure to report co-pays is a result of a reporting issue on the vendor's quarterly report to the plan.
- The plan is working with HN1, Therapy vendor, to correct reporting issue.

(4) Occupational Therapy –$5 per Visit

The plan reviewed the therapy encounters and examples provided by QSource. Our findings are as follows:

- The plan's therapy vendor is correctly collecting co-pays. The failure to report co-pays is a result of a reporting issue on the vendor's quarterly report to the plan.
- The plan is working with HN1, Therapy vendor, to correct reporting issue.

(5) Respiratory Therapy –$5 per Visit

The plan reviewed the therapy encounters and examples provided by QSource. Our findings are as follows:

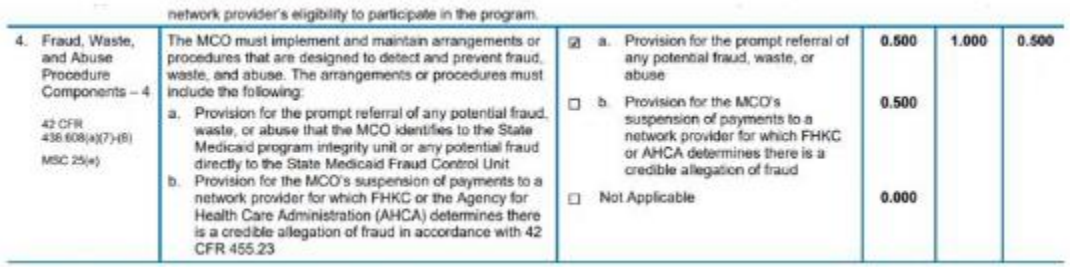
- Most of the claims processed correctly, they were denied for valid reasons, therefore, no co-pay was applied
- There were two instances where the co-pay did not apply and the benefit configuration has now been updated to capture this going forward.

(6) Speech Therapy –$5 per Visit

The plan reviewed the therapy encounters and examples provided by QSource. Our findings are as follows:

- The plan's therapy vendor is correctly collecting co-pays. The failure to report co-pays is a result of a reporting issue on the vendor's quarterly report to the plan.
- The plan is working with HN1, Therapy vendor, to correct reporting issue.

Table 12 Plan Response:



	network provider's eligibility to participate in the program.				
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

PLAN RESPONSE: Plan does not agree with letter "b" findings because at present no information is sent directly from FHKC to the plan concerning providers that FHKC has determined the presence of credible allegation of fraud. For providers who AHCA has determined there is a credible allegation of fraud the plan suspends payments to providers for both Medicaid and Florida Healthy Kids lines of business. We recommend that this element be moved to a suggestion and plan is updating policy accordingly.