



STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

and

FINANCIAL AND COMPLIANCE EXAMINATION

OF

AMERIGROUP TENNESSEE, INC.

NASHVILLE, TENNESSEE

**FOR THE PERIOD APRIL 1, 2007
THROUGH MARCH 31, 2008**

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DATE: October 28, 2009

The examination fieldwork for a Financial and Compliance Examination and Claims Processing Market Conduct Examination of AMERIGROUP Tennessee, Inc, Nashville, Tennessee, was completed August 25, 2008. The report of this examination is herein respectfully submitted.

I. FOREWORD

On June 23, 2008, the TennCare Oversight Division of the Tennessee Department of Commerce and Insurance (TDCI) notified representatives of AMERIGROUP, Tennessee, Inc. (AGP) of its intention to perform a market conduct, financial statement, and compliance examination. Fieldwork began on July 21, 2008, and ended on August 25, 2008.

This report includes the results of the market conduct examination “by test” of AGP’s claims processing systems. Further, this report reflects the results of an examination of financial statement account balances of AGP. This report also reflects the results of a compliance examination for its TennCare operations of AGP’s policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of AGP was conducted jointly by TDCI and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 3-6. of the Contractor Risk Agreement (CRA) for the West Tennessee Grand Region and Section 2.25 of the CRA for the Middle Tennessee Grand Region between the State of Tennessee and AGP, Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) § 56-32-115 and § 56-32-132.

AGP is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The financial examination focused on selected balance sheet accounts and the TennCare income statement submitted with its National Association of Insurance Commissioners (NAIC) Quarterly Statement as of March 31, 2008, the Medical Services Monitoring Report for the West Tennessee Grand Region as of March 31, 2008, and the Medical Loss Ratio Report for the Middle Tennessee Grand Region as of March 31, 2008.

The current market conduct examination by TDCI and the Comptroller focused on the claims processing functions and performance for AGP’s TennCare operations. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers. Additional testing

was performed as a follow-up to a TDCI readiness review for the Middle Tennessee operations which began April 1, 2007.

The compliance examination focused on AGP's TennCare provider appeals procedures, provider agreements and subcontracts, and the demonstration of compliance with non-discrimination reporting requirements.

Fieldwork was performed using records provided by AGP for TennCare operations before and during and after the onsite examination from July 21, 2008 through August 25, 2008.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that AGP's TennCare operations were administered in accordance with the CRA and state statutes and regulations concerning HMO operations, thus reasonably assuring that AGP's TennCare enrollees received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether AGP met certain contractual obligations under the CRA and whether AGP was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-101 *et seq.*;
- Determine whether AGP had sufficient financial capital and surplus to ensure the uninterrupted delivery of health care services for its TennCare members on an ongoing basis;
- Determine whether AGP's TennCare operations properly adjudicated claims from service providers and made payments to providers in a timely manner;
- Determine whether AGP's TennCare operations had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner.

III. PROFILE

A. Administrative Organization

AMERIGROUP Tennessee, Inc. (AGP) was incorporated under the laws of the State of Tennessee on April 26, 2006. AGP was licensed as an HMO by the State of Tennessee Department of Commerce and Insurance on March 29, 2007, for the purpose of participating as an MCO in the TennCare program for the Middle Tennessee Grand Region. AGP is a wholly-owned subsidiary of AMERIGROUP Corporation, Virginia Beach, Virginia. On November 1, 2007, AGP purchased

substantially all of the assets of Memphis Managed Care Corporation (MMCC) d/b/a TLC Family Care Health Plan (TLC) and TLC's wholly-owned subsidiary MidSouth Health Solution, Inc. Also, effective on October 31, 2007, the Bureau of TennCare consented to the assignment by MMCC and the assumption by AGP of all of MMCC's rights and obligations under the TennCare Agreement to AGP.

For Middle Tennessee operations, AGP contracts with the parent, AMERIGROUP Corporation, to provide management services. The management agreement provides that AMERIGROUP Corporation shall perform all administrative and support services necessary for the operation of AGP. These services include, but are not limited to, finance, management information systems, claim administration, telephonic member and provider services support, legal, regulatory, and provider credentialing. Also, the management agreement requires AGP to pay AMERIGROUP Corporation's costs, direct and indirect, for the services provided plus an administrative fee equal to ten (10%) percent of the direct and indirect costs. Indirect costs are costs incurred by AMERIGROUP Corporation for the benefit of the health plans which cannot be specifically identified to a particular health plan. These expenses are charged using a standard allocation methodology. Indirect costs are allocated based on the ratio of health plan premium revenue to the sum of the premium revenue of all health plans.

For AGP's TLC West Tennessee operations, essentially all management services were provided by the former employees of TLC at direct cost. All management services including claims processing operations remain at the Memphis office.

In addition to TennCare operations, in January 2008, AGP began offering three Medicare Advantage plans for those who are eligible for Medicare only and those who are eligible for both Medicaid and Medicare. For the quarter ending March 31, 2008, AGP reported Medicare premiums totaling \$988,359 with 412 members.

The officers and directors or trustees for AGP at March 31, 2008, were as follows:

Officers for AGP

Charles Brian Shipp, CEO/President
Alvin Brock King, Health Plan CEO/Vice President
Lorena Jean Stanley, COO/Vice President
Stanley Forrest Baldwin, Secretary/Vice President
Nicholas Joseph Pace, II, Assistant Secretary/Vice President
Richard Charles Zoretic, Assistant Secretary/Vice President
Scott Wayne Anglin, Treasurer/Vice President
James Ward Truess, Assistant Treasurer/Vice President
Karen Lint Shields, Assistant Treasurer/Vice President
Carol Ann Churchill, M.D., Medical Director/Vice President
James Allan Cousins, Treasurer
Victoria Jane Graves, Secretary

Lori-Don McNamee Gregory, Assistant Secretary
Margaret Mary Roomsburg, Vice President
Catherine Smith Callahan, Vice President
William Gardner Wood, M.D., Vice President

Directors or Trustees for AGP

Charles Brian Shipp
Nicholas Joseph Pace, II

Alvin Brock King
James Hui Teck Tan, M.D.

B. Brief Overview

Effective April 1, 2007, AGP entered into a full-risk contract with the TennCare Bureau to provide health services to enrollees in the Middle Tennessee Grand Region in exchange for a per member per month capitation payment.

As previously mentioned, on November 1, 2007, AGP purchased the TennCare operations of MMCC, d/b/a TLC. Effective July 1, 2002, the CRA with TLC was amended for TLC to temporarily operate under a non-risk agreement for the West Tennessee Grand Region. This period, otherwise known as the "stabilization period," was established to allow all MCOs a satisfactory period of time to establish financial stability, maintain continuity of a managed care environment for enrollees and assist the TennCare Bureau in restructuring the program design to better serve Tennesseans adequately and responsibly. TLC agreed to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures as they existed April 16, 2002, unless such a change received approval in advance by the TennCare Bureau.

During stabilization for the West Tennessee Grand Region operations, TLC received from the TennCare Bureau a monthly fixed administrative payment based upon the number of TennCare enrollees assigned to TLC. The TennCare Bureau reimbursed TLC for the cost of providing covered services to TennCare enrollees.

As of March 31, 2008, AGP had approximately 168,000 TennCare members for the West Tennessee Grand Region and had approximately 186,000 for the Middle Tennessee Grand Region.

C. Claims Processing Not Performed by AGP

For the Middle Tennessee Region, TennCare has contracted with other organizations for the administration and claims processing of these types of services:

- Dental
- Pharmacy

For the West Tennessee Region, TennCare has contracted with other organizations for the administration and claims processing of these types of services:

- Dental
- Pharmacy
- Behavioral Health

During the period under examination, AGP subcontracted with the following vendors for the provision of specific TennCare benefits and the processing and payment of related claims submitted by providers:

- Block Vision, Inc. for vision services for the Middle Tennessee Grand Region

IV. SUMMARY OF CURRENT FINDINGS

The summary of current factual findings is set forth below. The details of testing as well as management's comments to each finding can be found in Sections VI, VII, and VIII of this examination report.

A. Financial Deficiencies

1. A review of the payments for medical services and adjustments by AGP from April 1, 2008, through October 31, 2008, for dates of services before April 1, 2008, determined that the incurred but not reported (IBNR) estimated amount payable for TennCare operations in the Middle Tennessee Grand Region was understated as of March 31, 2008 by \$4,954,230. AGP has adjusted IBNR after the examination period by increasing claims margins from 7% to 7.5%. Until a significant history of medical claims payments have occurred, AGP should conservatively report medical claims payable.
(See Section V.A.3.)
2. The medical loss ratio report as submitted for the period April 1, 2007 through March 31, 2008, originally reported a medical loss (MLR) ratio of 97.40%. Administrative fees which have not been adjusted for examination findings were approximately 14% and premium taxes were 2% of total premiums. In order for AGP to break even the MLR would have to be approximately 84%. In June 2008, the Bureau of TennCare and AGP executed an agreement which provided additional funds of approximately \$47 million for home health, private duty nursing and a rate increase for April 2008 and May 2008. A review of the MLR report submitted for October 2008 indicates a decreased MLR of 91.70%. TDCI is concerned with the reported MLR percentage and its effect on eroding the plan's net worth.
(See Section V.D.)

3. The procedures and supporting documents to prepare the MLR report were reviewed. IBNR as a component of medical claims payable is also a significant component in MLR reporting. As previously noted in this report, claims payable was understated as of March 31, 2008 by \$4,954,230 for payments and adjustments by AGP through October 31, 2008.
(See Section V.D.)
4. The administrative allocations for taxes incurred by the parent and "Cost of Capital" should not be charged to AGP. In discussions subsequent to fieldwork, management agreed with the conclusions of TDCI and agreed to eliminate allocations for taxes incurred by the parent and "Cost of Capital" retroactively to December 31, 2007.
(See Section V.E.)

B. Claims Processing Deficiencies

1. For the West Tennessee Grand Region, TLC did not process TennCare claims timely in accordance with Tenn. Code Ann. § 56-32-126(b)(1) for the months of June 2007 and August 2007. TDCI assessed and TLC paid an administrative penalty in the amount of \$10,000 in violation of Tenn. Code Ann. § 56-32-126(b)(1).
(See Section VI.A.)
2. For the Middle Tennessee Grand Region, AGP did not process TennCare claims timely in accordance with Tenn. Code Ann. § 56-32-126(b)(1) for the months of February 2008 and April 2008. AGP was put on monthly testing for three months and consistently achieved compliance beginning May 2008.
(See Section VI.A.)
3. For the combined operation of the West and Middle Tennessee Grand Regions, AGP did not process TennCare claims timely in accordance with Tenn. Code Ann. § 56-32-126(b)(1) for the months of February 2008 and April 2008. AGP was put on monthly testing for three months and consistently achieved compliance beginning May 2008.
(See Section VI.A.)
4. AGP was awarded a TennCare contract for the Middle Tennessee Grand Region beginning April 1, 2007. A prior site visit of AGP was conducted by TDCI on August 27 through 29, 2007 to assess claims processing problems after implementation on April 1, 2007. AGP's Middle Tennessee operations experienced claims processing errors and configuration challenges resulting in delayed payments, inaccurate payments, and incorrect denials of provider claims. The recommendations and findings of the prior site visit were reviewed during the current examination. AGP has devoted significant resources to correct post implementation issues, however, deficiencies remain as revealed by

self-reported claim payment accuracy percentages and claims tested by TDCI and the Comptroller. (See Section VI.C.)

5. AGP's TLC operations failed to comply with Section 2-9.b. of the CRA for the West Tennessee Grand Region which requires that 97% of claims are paid accurately upon initial submission for the third and fourth quarter 2007 and the first quarter 2008.
(See Section VI.D.)
6. AGP failed to comply with Section 2.22.6 of the CRA for the Middle Tennessee Grand Region which requires that 97% of claims are paid accurately upon initial submission for the second, third, and fourth quarter 2007 and the first quarter 2008.
(See Section VI.D.)
7. For AGP's TLC operations, procedures for testing claims payment accuracy are deficient because the plan did not maintain the testing results of each attribute required per Section 2.9.m.2 of the CRA for the West Tennessee Grand Region.
(See Section VI.D.2.)
8. For AGP's Middle Tennessee operations, procedures for testing claims payment accuracy are deficient because the plan did not maintain the testing results of each attribute required per Section 2.22.6.4 of the CRA for the Middle Tennessee Grand Region.
(See Section VII.D.2.)
9. For one of the 10 claims selected for testing from claims processed by Block Vision, a rejected service line of the claim was not included in the prompt pay file submitted to TDCI. All processed service lines should be included in the prompt pay data files.
(See Section VI.F.)
10. For 14 of the 115 claims selected for testing from claims processed by AGP's Middle Tennessee operations, adjudication errors by AGP were discovered by TDCI and Comptroller.
(See Section VI.G.)
11. For eight of the 60 claims selected for testing from claims processed by AGP's TLC West Tennessee operations, adjudication errors by AGP were discovered by TDCI and the Comptroller.
(See Section VI.G.)
12. For five of the 60 claims selected for testing from claims processed by AGP's TLC West Tennessee operations, pricing accuracy errors by AGP were discovered by TDCI and The Comptroller.
(See Section VI.H.)

C. Compliance Deficiencies

1. For one of five provider complaints selected for testing for AGP's TLC West Tennessee operations, the plan incorrectly denied a medical claim for timely filing upon resubmission.
(See Section VII.A.)
2. For AGP's Middle Tennessee operations, policies and procedures for the processing of provider complaints were not in compliance with Tenn. Code Ann. § 56-32-126 during the examination period. Policies and procedures for the plan did not require a response to a reconsideration request within thirty calendar days. TDCI noted that the policies and procedures were updated before fieldwork in July 2008 to comply with Tenn. Code Ann. § 56-32-126.
(See Section VII.A.)
3. For AGP's Middle Tennessee operations, TDCI and the Comptroller selected as a test month provider complaints received by the plan in March 2008. The response by AGP to twelve complaints exceeded 30 days and one complaint exceed 60 days in violation of Tenn. Code Ann. § 56-32-126. For the twelve complaints that exceeded the 30 day response deadline, no acknowledgement was communicated to the provider that a response would exceed 30 days. For the one complaint that exceeded a 60 day response deadline, no agreement was made in writing with the provider noting that the response would exceed 60 days.
(See Section VII.A.)
4. For AGP's Middle Tennessee operations, TDCI and the Comptroller selected twelve complaints for further testing. For eight of the twelve complaints tested, the date in the claims processing system for the "remit date" or the resolution date did not match the "End Date" or "Response Date" on the complaint log. The plan must ensure the complaint logs correctly report resolution or response dates to ensure compliance with Tenn. Code Ann. § 56-32-126.
(See Section VII.A.)
5. For the AGP's Middle Tennessee operation, the following deficiencies were noted in the review of the provider manual:
 - The provider manual was approved by TDCI on January 2007, however the version communicated to providers on the company website does not agree with the approved version.
 - On the company website, providers were informed of 36 updates to the provider manual as of July 2008. These updates to the provider manual should be submitted as material modifications to AGP's operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1).

- All of AGP's provider agreements incorporate by reference the requirements of the provider manual. Updates to the provider manual require AGP to meet contractual provider notification requirements. Eleven provider agreements were tested to determine if AGP complied with notification requirements of Section 2.12.7.35 of the CRA for the Middle Tennessee Grand Region. None of the eleven provider agreements files contained evidence of notification requirements.
(See Section VII.B.)
- 6. TDCI approved on September 17, 2007 amended provider agreement templates submitted by AGP. As of fieldwork in July 2008, ten of the twelve provider agreements selected for testing have not been executed using the approved amended provider agreement templates. Additionally, all twelve executed provider agreements were deficient since they did not include the amended provider agreement language requirements of the CRA. AGP should develop procedures to promptly amend provider agreements when amendments to the CRA update provider agreement language requirements.
(See Section VII.C.)
- 7. For the period ending December 31, 2007, AGP had not complied with Section 2-10.h.4. of the CRA for the West Tennessee Grand Region and Section 2.21.10.2 of the CRA for the Middle Tennessee Grand Region which require audits of the plan be subject to prior approval of the Comptroller of the Treasury and to be submitted on the standard "Contract to Audit Accounts" agreement.
(See Section VII.K.)
- 8. TDCI recommends that AGP's annual review of political contributions incorporates and documents specific testing of the conflict of interest provisions of Section 4-7. of the CRA for the West Tennessee Grand Region and Section 4.19 of the CRA for the Middle Tennessee Grand Region.
(See Section VII.L.)

V. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, AGP is required to file annual and quarterly NAIC financial statements in accordance with NAIC guidelines with the Tennessee Department of Commerce and Insurance. The department uses the information filed on these reports to determine if AGP meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash, if necessary, to pay outstanding claims. "Non-admitted" assets such as furniture,

equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

At March 31, 2008, AGP reported \$103,751,476 in admitted assets, \$83,837,544 in liabilities and \$19,913,932 in capital and surplus on the Quarterly Statement as of March 31, 2008 submitted June 2, 2008. AGP reported total net loss of \$26,528,334 on the statement of revenue and expenses.

1. Capital and Surplus

Tenn. Code Ann. § 56-32-112(a)(2) requires AGP to establish and maintain a minimum net worth equal to the greater of (1) \$1,500,000 or (2) an amount totaling 4% of the first \$150 million of annual premium revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of \$150 million for the prior calendar year.

Tenn. Code Ann. § 56-32-112(a)(2) includes in the definition of premium revenue “any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions of the federal Social Security Act (title XIX), and regulations promulgated pursuant thereto, or pursuant to any other federal law as adopted by amendment to the required title XIX state plan...” Based on this definition, all TennCare payments made to an HMO licensed in Tennessee are to be included in the calculation of net worth and deposit requirements, regardless of the reporting requirements for the NAIC statements.

Effective April 1, 2007, AGP executed a contract with the TennCare Bureau to serve enrollees in the Middle Tennessee Grand Region. Section 2.21.5.1 of the Middle Tennessee CRA requires AGP to maintain a minimum net worth equal to the requirements of Tenn. Code Ann. § 56-32-112(a)(2). Additionally, Section 2.21.5.2 of the Middle Tennessee CRA addresses the calculation of an enhanced minimum net worth in the event of a significant enrollment expansion as defined in Tenn. Code Ann. § 56-32-103(c)(2). A significant enrollment expansion is defined as an expansion of an HMO’s enrollee population of more than 10% in a six month period. The calculation of the minimum net worth for a significant enrollment expansion per Section 2.21.5.2 of the Middle Tennessee CRA shall be based upon annual projected premiums including the estimated premiums for the additional enrollment. Estimated premiums will be based on the capitation payment rates in effect at the time of the calculation and projected future enrollment. The formula set forth in Tenn. Code Ann. 56-32-112(a)(2) shall then be applied to the annualized projected premiums to determine the enhanced minimum net worth requirement. AGP is required to maintain the enhanced minimum net worth balance until AGP has completed a full calendar year with the significant expanded enrollment.

2008 Statutory Net Worth Calculation

At March 31, 2008, AGP reported capital and surplus totaling \$19,913,932. Total premiums estimate of \$793,789,579 was utilized in the calculation of AGP's 2008 statutory net worth calculation. AGP's statutory net worth requirement is \$15,656,844 ($\$150,000,000 \times 4\% + (\$793,789,579 - \$150,000,000) \times 1.5\%$). AGP's reported net worth at March 31, 2008, was \$4,257,088 in excess of the minimum required.

TennCare Premium Revenue for the Examination Period

For the examination period April 1, 2007, through March 31, 2008, the following is a summary of AGP's premium revenue from TennCare operations as defined by Tenn. Code Ann. § 56-32-112(a)(2):

West Tennessee Grand Region

Received During the Period November 1, 2007 through
March 31, 2008

Reimbursement for medical payments	\$130,216,406	
Administrative fee payments	9,634,283	
Reimbursement for administrative incentive bonus	1,340,565	
Reimbursement for premium tax payments	<u>1,865,182</u>	
Total West Tennessee premiums for the period November 1, 2007 through March 31, 2008		\$143,056,436

Middle Tennessee Grand Region

Received During the Period April 1, 2007 through
March 31, 2008

Capitation Payments	509,494,992	
Administrative Services Only Payments	<u>625,547</u>	
Total Middle Tennessee premiums for the period April 1, 2007, through March 31, 2008		<u>510,120,539</u>
Total premiums for TennCare operations for the period April 1, 2007, through March 31, 2008		<u>\$653,176,975</u>

The CRA includes shared risk incentives for the administrative fee payments received by the plan. AGP earned additional funds from the bonus pool of \$1,340,565 for the period November 1, 2007, through June 30, 2008, for favorable performance related to risk initiatives.

Subsequent Event Related to TennCare Premium Revenue

In June 2008, TennCare Bureau and AGP agreed to a material retroactive rate increase of approximately \$47.3 Million (approximately \$35.5 Million for the period April 1, 2007 through December 31, 2007, and \$11.8 Million for the period January 1, 2008 through March 31, 2008) related to home health and private duty nursing expenditures and retro-enrollment for the period April 1, 2007 through March 31, 2008. AGP reported this as revenue and a receivable on the NAIC Quarterly Statement as of June 30, 2008. Also, AGP correctly reported the retroactive payment amounts in the June 2008 Medical Loss Ratio (MLR) report on an incurred basis.

2. Restricted Deposit

The risk contract for the Middle Tennessee Grand Region requires AGP to have a restricted deposit equal to the amount calculated as statutory minimum net worth. AGP's statutory net worth requirement is \$15,656,844. AGP has on file with TDCI the necessary safekeeping receipts for deposits totaling \$15,700,000.

3. Claims Payable

As of March 31, 2008, AGP reported \$74,247,299 claims unpaid on the NAIC Quarterly Statement as of March 31, 2008. Of the total claims unpaid, \$73,487,736 represents an estimate for the Middle Tennessee Grand Region at-risk operations for TennCare for the period April 1, 2007 through March 31, 2008. The remaining amount of \$759,562 (\$74,247,299 less \$73,487,736) is related to the Medicare line of business. None of the reported \$74,247,299 total claims unpaid represents an estimate for West Tennessee Grand Region non-risk operations for TennCare.

A review of the payments for medical services and adjustments by AGP from April 1, 2008, through October 31, 2008, for dates of services before April 1, 2008, determined that the incurred but not reported estimated amount payable for TennCare operations in the Middle Tennessee Grand Region was understated as of March 31, 2008 by \$4,954,230. AGP has adjusted IBNR after the examination period by increasing claims margins from 7% to 7.5%. Until a significant history of medical claims payments have occurred, AGP should conservatively report medical claims payable.

Management Comments

AGP utilizes the expertise of internal and external actuaries to set the reserve estimates for each reporting period based on the most recent claims payment information using a consistent methodology. With the benefit of hindsight analysis of claims paid, these estimates were determined to be understated as

of March 31, 2008. Based on the claims experience of AGP, TennCare adjusted the premium rates retroactively for the applicable period.

B. TennCare Operating Statements

1. TennCare Operating Statement for Non-Risk Operations of the West Tennessee Grand Region

As previously mentioned, the West Tennessee CRA does not hold AGP financially responsible for medical claims. This type of arrangement is considered "administrative services only" (ASO) by the NAIC. Under the NAIC guidelines for ASO lines of business, the financial statements for an ASO exclude all income and expenses related to claims, losses, premiums, and other amounts received or paid on behalf of the uninsured ASO. In addition, administrative fees and revenue are deducted from general administrative expenses. Further, ASO lines of business have no liability for future claim payments; thus, no provisions for IBNR are reflected on the balance sheet.

Although AGP is under an ASO arrangement as defined by NAIC guidelines, the West Tennessee CRA requires a deviation from ASO reporting guidelines. The required submission of the TennCare Operating Statement should include quarterly and year-to-date revenues earned and expenses incurred as a result of the contractor's participation in the State of Tennessee's TennCare program as if TennCare operations for AGP in the West Tennessee Grand Region were still operating at-risk. As stated in Section 2-10.h.2. of the CRA, AGP is to provide "an income statement detailing the CONTRACTOR's fourth quarter and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the State of Tennessee's TennCare Program." TennCare HMOs provide this information each quarter on the Report 2A submitted as a supplement to the NAIC financial statements.

No deficiencies were noted in the preparation of the TennCare Operating Statement for the West Tennessee Grand Region.

2. TennCare Operating Statement of the At-Risk Operations of the Middle Tennessee Grand Region

Sections 2.30.14.3.3 and 2.30.14.3.4 of the Middle Tennessee CRA require each submission of NAIC financial statements to contain a separate income statement detailing the quarterly and year-to-date revenues earned and expenses incurred as a result of participation in the TennCare program.

No deficiencies were noted in the preparation of the TennCare Operating Statement for the Middle Tennessee Grand Region.

C. Medical Services Monitoring

Effective July 1, 2002, the West Tennessee CRA requires AGP to submit a Medical Services Monitoring Report (MSM) on a monthly basis. The MSM reports medical payments and IBNR based upon month of service as compared to a target monthly amount for the enrollees' medical expenses. Although estimates for incurred but not reported claims for ASO plans are not included in the NAIC financial statements, these estimates are required to be included in the MSM. AGP submitted monthly MSM reports which reported actual and estimated monthly medical claims expenditures to be reimbursed by the TennCare Bureau. The estimated monthly expenditures are supported by a letter from an actuary which indicates that the MSM estimates for IBNR expenses have been reviewed for accuracy.

No discrepancies were noted during the review of documentation supporting the amounts reported on the Medical Services Monitoring Report.

D. Medical Loss Ratio Report

Section 2.30.14.2.1 of the Middle Tennessee CRA requires:

The CONTRACTOR shall submit a *Medical Loss Ratio Report* monthly with cumulative year to date calculation using the forms in Attachment IX, Exhibit N. The CONTRACTOR shall report all medical expenses and complete the supporting claims lag tables. This report shall be accompanied by a letter from an actuary, who may be an employee of the CONTRACTOR, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy. The CONTRACTOR shall also file this report with its NAIC filings due in March and September of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report must reconcile to NAIC filings including the supplemental TennCare income statement.

The medical loss ratio report submitted for the period April 1, 2007 through March 31, 2008 originally reported a medical loss ratio of 97.40%. Administrative fees which have not been adjusted for examination findings were approximately 14% and premium taxes were 2% of total premiums. In order for AGP to break even the MLR would have to be approximately 84%. As previously noted, in June 2008, the TennCare Bureau and AGP executed an agreement which provided additional funds of approximately \$47 million for home health, private duty nursing and a rate increase for April 2008 and May 2008. A review of the MLR report submitted for October 2008 indicates a decreased MLR of 91.70%. TDCI is concerned with the reported MLR percentage and its effect on eroding the plan's net worth.

Management Comments

AGP monitors net worth on a quarterly basis and as of June 30, 2009 had a net worth of \$56.6 million in excess of the statutory net worth requirement.

The procedures and supporting documents to prepare the MLR were reviewed. IBNR as a component of medical claims payable is also a significant component in MLR reporting. As previously noted in this report, claims payable was understated as of March 31, 2008 by \$4,954,230 for payments and adjustments by AGP through October 31, 2008.

Management Comments

AGP utilizes the expertise of internal and external actuaries to set the reserve estimates for each reporting period based on the most recent claims payment information using a consistent methodology. With the benefit of hindsight analysis of claims paid, these estimates were determined to be understated as of March 31, 2008. Based on the claims experience of AGP, TennCare adjusted the premium rates retroactively for the applicable period.

E. Administrative Allocations

On April 25, 2008, TDCI approved AGP's First Amended and Restated Administrative and Support Services agreement (management agreement). In the management agreement, AMERIGROUP Corporation agree to provide resources or arrange for the provision of certain administrative and support services required by AGP to fulfill its requirements of the Contractor Risk Agreement with the TennCare Bureau. Section 3.1.1 "Compensation" outlines the method of compensation of AGP to the AMERIGROUP Corporation and is stated below:

"Plan shall pay to AMERIGROUP AMERIGROUP's costs, direct and indirect, for the services provided herein (the "Costs"), plus an administrative fee equal to ten (10%) percent of the Costs (the "10% Administration Fee") (collectively, the Costs and the 10% Administration Fee shall be hereinafter referred to as the "Administrative Fee"). Indirect costs are costs incurred by AMERIGROUP for the benefit of the health plans which cannot be specifically identified to a particular health plan. These expenses are charged using a standard allocation methodology. These costs include finance, legal, regulatory, network development, treasury, information technology services, associate services, benefit administration and corporate governance. Indirect costs are allocated based on the ratio of health plan premium revenue to sum of the premium revenue of all health plans."

TDCI's review of administrative allocations found that AMERIGROUP Corporation charges AGP via the intercompany account allocations for taxes incurred by the parent. On December 12, 2006, TDCI approved a tax allocation agreement between

the AGP and the parent. The approved tax allocation agreement does not indicate an allocation shall be made for the tax incurred by the parent.

Additionally, the administrative allocations from the parent include charges for "Cost of Capital". Based on a discussion with AMERIGROUP Corporation's management during examination field work, "Cost of Capital" is an allocation of an investment cost with an imputed interest rate that AMERIGROUP Corporation would have made if it had not invested in AGP. This is an opportunity cost.

The administrative allocations for taxes incurred by the parent and "Cost of Capital" should not be charged to AGP. In discussions subsequent to fieldwork, management agreed with the conclusions of TDCI and agreed to eliminate allocations for taxes incurred by the parent and "Cost of Capital" retroactively to December 31, 2007. Based on an analysis of AMERIGROUP Corporation's Management Fee True-up for March 2008, the following amounts should be excluded from the administrative allocation for the periods identified:

Description:	January 1 to March 31, 2008
Taxes	188,001.75
Cost of Capital	644,965.99
Subtotal Indirect Allocation	832,967.74
Plus: 10% of Indirect Costs	<u>83,296.77</u>
Total Excess Management Fees	<u>916,264.51</u>

An adjustment and restatement to net worth as March 31, 2008 is not recommended by TDCI. The effect of this adjustment was reflected in the subsequent NAIC financial reports submitted by AGP.

Management Comments

AMERIGROUP Corporation adjusted its 2008 management fee calculation to reflect a reduction for the exceptions noted above. Additionally, effective January 1, 2009, AMERIGROUP Corporation and AGP entered into an amended restated administrative services agreement, which was approved by TDCI.

F. Schedule of Examination Adjustments to Capital and Surplus

An adjustment and restatement to net worth as March 31, 2008 is not recommended by TDCI. The effect of an adjustment for the retroactive rate increase to premiums (See Section VI.A.1.), understated medical claims payable (See Section VI.A.3.) and elimination of certain administrative allocations (See Section VI.E.) are reflected in the subsequent NAIC financial reports submitted by AGP including the NAIC Annual Statement as December 31, 2008.

VI. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames set forth in Tenn. Code Ann. § 56-32-126(b)(1) and Section 2-18. of the West Tennessee CRA and Section 2.22.4 of the Middle Tennessee CRA. The statute mandates the following prompt payment requirements:

The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.

(A) “Pay” means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.

(B) “Process” means the health maintenance organization must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either that the claim had been paid or informing the provider that a claim has been either partially or totally “denied” and specify all known reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice must specifically identify all such information and documentation.

During the examination period, TDCI determined compliance with Tenn. Code Ann. § 56-32-126(b)(1) by testing in three-month increments data file submissions from each of the TennCare MCOs. Each month is tested in its entirety for compliance with the prompt pay requirement of Tenn. Code Ann. If a TennCare MCO fails to meet the prompt pay standards in any of the three months tested, TDCI, at a minimum, requires claims data submissions on a monthly basis for the next three months to ensure the MCO remains compliant.

Although AGP purchased TLC on November 1, 2007, TLC's results of prompt pay testing are presented below for the period under examination.

West Tennessee Grand Region	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
April 2007	90%	99.8%	Yes
May 2007	93%	99.6%	Yes
June 2007	83%	90.2%	No
July 2007	92%	99.8%	Yes
August 2007	89%	91.2%	No
September 2007	93%	99.9%	Yes
October 2007	98%	100.0%	Yes
November 2007	96%	99.8%	Yes
December 2007	93%	100.0%	Yes
January 2008	91%	99.7%	Yes
February 2008	90%	99.5%	Yes
March 2008	99%	99.7%	Yes

TLC did not process TennCare claims timely in accordance with Tenn. Code Ann. § 56-32-126(b)(1) for the months of June 2007 and August 2007. TDCI assessed and TLC paid an administrative penalty in the amount of \$10,000 in violation of Tenn. Code Ann. § 56-32-126(b)(1).

Management Comments

Management concurs.

The following table represents the results of prompt pay testing for claims processing in the Middle Tennessee Grand Region by AGP. The results include claims processed by subcontractors for vision claims and non-emergency transportation services.

Middle Tennessee Grand Region	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
April 2007	100%	100.0%	Yes
May 2007	99%	100.0%	Yes
June 2007	97%	99.9%	Yes
July 2007	100%	99.9%	Yes
August 2007	99%	99.9%	Yes
September 2007	98%	99.8%	Yes
October 2007	99%	99.9%	Yes
November 2007	95%	99.9%	Yes
December 2007	98%	99.9%	Yes
January 2008	98%	99.7%	Yes
February 2008	96%	98.1%	No
March 2008	99%	99.7%	Yes
April 2008	98%	99.1%	No

AGP did not process TennCare claims timely in accordance with Tenn. Code Ann. § 56-32-126(b)(1) for the months of February 2008 and April 2008. AGP was put on monthly testing for three months and consistently achieved compliance beginning May 2008.

Management Comments

Management concurs. For the month of February AGP missed the 60 day turnaround time requirements due to a system issue that was identified with hospital claims submitted with NDC codes. Hospital claims submitted with NDC code were rejected in error. All of the claims were recycled through our system and processed correctly. We failed to meet the performance guarantee due to aged received dates on some of the claims.

For the month of April AGP missed the 60 day turnaround time requirements due to invalid NPI rejections on atypical providers. Claims billed by an ambulance group were rejected in error. All of the claims were recycled through our system and processed correctly. We failed to meet the performance guarantee due to aged received dates on some of the claims.

The system in both of these situations was corrected when the issue was identified.

The results of claims processing for the West Tennessee Grand Region and Middle Tennessee Grand Region are combined in the following table.

AGP West and Middle TennCare Operations	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
November 2007	95%	99.9%	Yes
December 2007	96%	99.9%	Yes
January 2008	95%	99.7%	Yes
February 2008	94%	98.7%	No
March 2008	99%	99.7%	Yes
April 2008	96%	99.3%	No

For the combined operations of the West and Middle Tennessee Grand Regions, AGP did not process TennCare claims timely in accordance with Tenn. Code Ann. § 56-32-126(b)(1) for the months of February 2008 and April 2008. AGP was put on monthly testing for three months and consistently achieved compliance beginning May 2008.

Management Comments

Management concurs. For the month of February, AGP missed the 60 day turnaround time requirements due to a system issue that was identified with hospital claims submitted with NDC codes. Hospital claims submitted with NDC code were rejected in error. All of the claims were recycled through our system and processed correctly. We failed to meet the performance guarantee due to aged received dates on some of the claims.

For the month of April, AGP missed the 60 day turnaround time requirements due to invalid NPI rejections on atypical providers. Claims billed by an ambulance group were rejected in error. All of the claims were recycled through our system and

processed correctly. We failed to meet the performance guarantee due to aged received dates on some of the claims.

B. Determination of the Extent of Test Work on the Claims Processing System

Several factors were considered in determining the extent of testing to be performed on AGP's claims processing system.

The following items were reviewed to determine the risk that AGP had not properly processed claims:

- Prior TLC examination findings related to claims processing,
- Complaints or independent reviews on file with TDCI related to inaccurate claims processing,
- Results of prompt pay testing by TDCI,
- Results reported on the claims payment accuracy reports submitted to TDCI and the TennCare Bureau,
- Review of the preparation of the claims payment accuracy reports,
- Review of internal controls related to claims processing, and
- Follow-up to TDCI Recommendations and Findings as the result of a Site Visit conducted August 27 through 29, 2009.

As noted below, TDCI discovered deficiencies related to AGP's procedures for preparing the claims payment accuracy reports. Additional testing was performed as a follow-up to TDCI's claims processing readiness review for the Middle Tennessee Grand Region. A discussion of the additional testing and results of the follow-up can be found in Section VII.C. of this report. The standard claims sample size of 60 claims was selected for testing in the West Tennessee Grand Region while an expanded sample size of 125 claims was selected for testing in the Middle Tennessee Grand Region. A discussion of the sample selection methodology can be found in Section VII.E. of this report.

C. Post Implementation Issues for AGP's Middle Tennessee Operations

AGP was awarded a TennCare contract for the Middle Tennessee Grand Region beginning April 1, 2007. A prior site visit of AGP was conducted by TDCI on August 27 through 29, 2007 to assess claims processing problems after implementation on April 1, 2007. AGP's TennCare Middle Tennessee operations have experienced claims processing errors and configuration challenges resulting in delayed payments, inaccurate payments, and incorrect denials of provider claims. The following are the recommendations and findings as a result of the prior site visit. During the current examination, a follow-up to each issue was discussed and responded to by plan representatives. AGP has devoted significant resources to correct post implementation issues, however, deficiencies remain as revealed by

self-reported claim payment accuracy percentages and claims tested by TDCI and the Comptroller.

Management Comments

Management concurs; however, we are pleased to report that since March 2009 it has met or exceeded the claim payment accuracy requirement of 97%. As stated above, AGP has and continues to devote significant resources to correct issues created during implementation of health plan and current claim payment accuracy performance indicates this resource commitment achieved the desired effect.

TDCI RECOMMENDATIONS – SITE VISIT AUGUST 27 THROUGH 29, 2007

1. Late Contracting of Providers

Since many providers were contracted very close to or even after April 1, 2007, the provider credentialing and the loading and testing of the provider configurations in the claims system were delayed. A sufficient time for testing was not available. A variety of issues arose in which AGP did not have time to consider before implementation or were the result of unique classes of claim situations peculiar to the TennCare Program. For example, AGP did not expect the large volume of private duty nursing services from home health providers. The home health issues included multiple entity provider configuration, coding issues and submission problems.

Follow-up During Current Examination

Is there currently a delay or backlog in credentialing and configuring providers into the system?

Management Comments

No current delay or backlog exists for providers who are currently in the credentialing process, including system configuration.

Follow-up During Current Examination

There are examples in the issue log where there were credentialing delays or paperwork delays to get providers loaded. Have processes been improved to credential providers especially if they are changes to rosters of physician groups?

Management Comments

Currently, the PDM area has a 5 business day turnaround service level agreement (SLA) to complete entry of rosters into Facets. Health Plan Services

and the Health Plan have taken necessary steps to adjust the internal workflow to ensure rosters are reviewed for accuracy and data entered within the agreed upon SLA.

2. Late Subcontracting For Transportation Administration

AGP subcontracted extremely late with an agency to authorize and submit claims for AGP's transportation vendors. The subcontractor was not ready for the volume of calls at go-live on April 1, 2007. AGP and the subcontractor did not have the time available to test the transfer of claims electronically. Significant payment delays occurred for all transportation claims payments. AGP issued advance payments to some transportation providers and provided staffing to the subcontractor until it could increase its staffing levels.

Follow-up During Current Examination

What type of monitoring has been performed over the transportation subcontractor and what are the results?

Management Comments

Amerigroup contracted with Mid-West CSA to coordinate trip scheduling and vendor dispatch for our transportation vendors. AGP assisted with the provision of staffing until May 2007 when the CSA acquired sufficient employees. Since that time, Amerigroup has monitored the transportation network through regular reporting of call center statistics provided by the CSA; there have been no substantial delays or reductions in service levels.

AGP issued advances to some of its transporters in 2nd quarter 2007 to temporarily address payment delays. Claims are continually monitored and issues are addressed as needed. With the pending transition of transportation vendors, AGP has recouped most of the advances issued during the 2nd quarter.

Effective 8/18/08, we will move to a single vendor (TN Carriers) to coordinate both scheduling and actual transportation delivery for our members. This transition is aligned with the state of TN's Non-emergency transportation requirements that must be implemented by 9/1/08. We will monitor performance through state mandated standards as well as internal requirements.

3. Fee Schedule Establishment

AGP's contracted reimbursement methodology for most providers is based upon a contracted percentage of Medicare payment rates. The provider contracts do not identify payment rates where services covered by Medicaid are not paid by Medicare. AGP developed a separate fee schedule for Medicaid services not

covered by Medicare. This schedule has required updates since go-live as providers discover problems in reimbursement levels.

Follow-up During Current Examination

TDCI was provided the fee schedule for services not covered by Medicare after the site visit in May 2008. The last items that were added were the revenue codes related to regional mental health institutes. Have there been any updates since then?

Management Comments

The file provided at the May 2008 site visit was a listing of services (procedure & revenue code) not covered by Medicare. This list is used by Claims Analyst staff when determining if AMERIGROUP should cover a submitted service(s) as the primary or secondary when a member has Medicare coverage on file. It is not a separate fee schedule (do not have specific fees tied to this listing).

4. PCP Assignment and Relationships

AGP allowed an exception for the first 90 days of plan operations to their policy requiring enrollees to first seek services from an assigned primary care provider (PCP) or a provider with an established relationship with the assigned PCP. A backlog of provider relationships which had not been established in the claims processing system resulted in incorrect claims denials.

Follow-up During Current Examination

Does AGP feel that the relationships are now correct or will this not be truly satisfied until AGP completes the audit of fee tables?

Management Comments

AGP's relationships with its PCP network have greatly improved since plan implementation. Due to overall improved service levels, our *relationship* with the PCP's is now good – if issues do arise, we are able to respond and resolve much more quickly.

5. Payment Configuration for Case Rates

The complex methodology for the payment of case rates to Community Mental Health Centers (CMHCs) for priority members has been difficult to establish in the claims processing system. On August 28, 2007, AGP paid most CMHCs to true-up case rate payments since April 1, 2007 through an alternative method outside of the claims processing system. The alternate method will continue at least through the remainder of the year. TDCI is concerned that claim encounter

submissions from CMHCs are not current since this is the basis for the case rate payments.

Follow-up During Current Examination

The alternative method continued into 2008. During the May 2008 visit, AGP discussed the possibility of renegotiating the CMHC contracts to another payment method. What is status and target dates? The new payment methods have not been submitted for material modification to TDCI.

Management Comments

Alternative payment methodologies have been drafted and reviewed internally to address the complex methodology currently in place with CMHC providers, including one methodology that would allow for claims payments to come through Facets. This methodology is currently being tested make sure that resulting contracts can be configured in Facets and claims can be paid from Facets. In the event Facets is unable to be configured or cannot pay per the proposed payment methodology, AGP will request approval from TDCI of a contract template that allows for quarterly reconciliations and payments outside of the Facets system. Ultimately, AGP is hopeful that it will be able to negotiate fee-for-services agreements with its providers and if case rates are necessary, they will be for case management services only. An amendment for one provider was recently reviewed and approved that removed the case rate from the contract and payment is based on services rendered on a per diem basis.

6. Provider Identification

The selection of the correct provider for processing and payment occurs during the initial phases of processing a claim. A provider may have several payment configurations. Current system logic sometimes selected the wrong provider payment configuration or even the wrong provider with a similar name. AGP has increased manual verification of the provider selected and has developed a project team to resolve this issue.

Follow-up During Current Examination

Error continues at least through July 31, 2008. Are the updates to provider selection processes still on target? What if the updates fail? Is there an alternate plan since it continues to cause AGP to fail claims payment accuracy standards?

Management Comments

The improvements to the provider selection logic were broken out into two phases. The first phase was to ensure the proper selection between the billing

or the rendering provider. This first phase improvement was tested and put into production on 6/6/08. The second phase utilizes multiple data elements such as tax ID, Medicaid ID and name to find that a single, unique match. This second phase improvement is scheduled to go into production on 9/5/08.

Once these enhancements are in place, we will analyze any incorrect selections to determine the root cause. In most cases, we believe it may require changes to the provider's data recorded in our system or we may need to enhance the logic further to accommodate some unique scenarios. The logic we have built is being tested thoroughly to ensure the right provider is selected. When we are not 100% sure, then we pend item for manual review by our Provider Data Management team.

7. Staffing Levels

AGP is currently recruiting additional staff and has shared plans to decrease response times to provider complaints. AGP should continue to seek to resolve the remaining open system issues and respond to provider claims payment issues in a timely manner.

Follow-up During Current Examination

Does AGP feel that it is now up to an adequate level of staffing? Are there any key positions unfilled?

Management Comments

AGP restructured the PR department to better handle servicing of providers. PR added an area dedicated to hospital/ancillary contracting and servicing with a manager and six account executives. Additionally, the health plan added 2 additional claims research positions to help investigate and resolve claim issues. In October 2007, the health plan also set up a Bureau Service Desk to assist in the resolution of provider issues. The Bureau Service Desk coordinates getting timely responses back to TDCI, TennCare, providers, etc. as it monitors the requests for resolution. There are currently no key positions unfilled within the PR department and it is staffed adequately to service providers efficiently. In recent months, we have seen a reduction in the volume of provider complaints within the health plan.

8. Encounter Submissions

AGP should proactively search for provider types where payments and encounters are lower than expected. An example discovered through the true-up process for case rates identifies some CMHCs encounter submissions are lacking. A provider class that appears to meet this criterion is regional mental health institutes based on a review of paid claims data files.

Follow-up During Current Examination

During the site visit, some CMHCs were deficient in encounter data submission based case rate settlement spreadsheets. Has AGP communicated to the providers and how have they responded?

Management Comments

AGP has worked with its CMHC providers to stress the importance of timely claims filing and has collaborated with these providers to remove barriers which lead to lower than actual encounter submissions. For example, AGP worked with one provider to identify claims not in our systems and a timeframe for a large submission of claims to come into our system. Recently AGP staff assisted one of our CMHC's with a large volume of claims (30,000 in one week) to ensure we were in receipt of all claims for claims payment and encounter data purposes.

9. Provider Contract Reimbursement Methodologies

As discussed, many of AGP's provider contracts do not reflect the payment of services not covered by Medicare through a separate fee schedule developed for Tennessee. Future amendments to provider contracts should clearly reflect the separate Tennessee rate sheet.

Follow-up During Current Examination

Has AGP considered this recommendation?

Management Comments

AGP is currently working on a national fee schedule for gap codes that would reflect payment for covered TennCare services that are non-covered Medicare services.

10. Prompt Payment Percentage for Case Rate Payments

TDCI and AGP will have to establish alternate methods for determining prompt pay percentages for claims paid and denied through case rate true-ups. Since the date of payment will not be maintained in the system, separate data files related to claims processed through case rate true-ups will have to be submitted to TDCI.

Follow-up During Current Examination

Have there been any gaps over more than 30 days between settlements for any of the case rate CMHCs?

Management Comments

The recent payments have been three to five weeks apart since our discovery in April that hundreds of the monthly case rates paid to date are for members showing Priority status on the state's 834 eligibility tape that are not paid as Priority on the 820 premium tape. As a result, all of the CMHCs have been paid case rates for at least five percent more member months than would be classified as Priority based on the TennCare 820 payment tapes. In addition, AGP discovered that many of the paid intensive case rates (CTT, CCFT, PACT) did not have authorizations on AGP's system. Neither of these issues has been recouped from any of the agencies, resulting in ongoing overpayments based on member Priority status at this time.

11. Claims Payment Accuracy Preparation

TDCI recommends that the TennCare Bureau rescind its exception to CRA 2.21.9. which states, "the CONTRACTOR's internal audit department shall be responsible for performance of the claims payment accuracy tests as described in Section 2.22.6 of this Agreement." During the review of policies and procedures before April 1, 2007, the TennCare Bureau granted an exception to the CRA to allow AGP to utilize their Quality Assurance department versus AGP's Internal Audit to perform claims payment accuracy testing. The Tennessee HMO has contracted with the parent corporation for the processing and payment of claims submitted by providers. The Quality Assurance Department is a division of the claims operations in Virginia Beach, Virginia, and Tampa Bay, Florida, and organizationally reports to the CEO of the parent organization. The Quality Assurance department at the corporate level provides an extremely valuable service in the testing of claims processed. Regardless of the CRA requirements, corporate claims operations would have performed this self testing and this testing should continue. TDCI believes benefits would be gained by the preparation of the claims payment accuracy reports by a division separate from the claims department as intended by the CRA. Other TennCare HMOs initially complained about this requirement but have since provided TDCI positive feedback after implementing and complying with this CRA requirement.

AGP does have a corporate Internal Audit function as part of parent operations but a better solution would be for the Tennessee operations to have its own distinct internal audit function. The Tennessee HMO has recently updated the organizational structure to include a Director of Risk & Compliance. An internal auditor within this unit could test and report claims payment accuracy percentages directly to the board of directors of the Tennessee HMO. This new

unit would act as an advocate for the Tennessee HMO since the Tennessee HMO relies on the parent corporation for management services and essentially all claims processing. Additionally, this unit would become familiar with the unique aspects of claims processing requirements of the Tennessee HMO.

Follow-up During Current Examination

AGP began utilizing an internal auditor from the Memphis operations to prepare claims payment accuracy reports beginning with the First Quarter 2008 report.

TDCI FINDINGS – SITE VISIT AUGUST 27 THROUGH 29, 2007

1. AGP incorrectly reported a second quarter claims payment accuracy percent of 94.21%. The correct accuracy percentages based upon supporting sample results is 90.86%. AGP agreed to adjust the reporting for the second quarter 2007.

Follow-up During Current Examination

None required.

2. AGP does not maintain for audit and verification purposes an attribute sheet documenting the tests applied to each claim tested for claims payment accuracy as required by Section 2.22.6.5. of the CRA. AGP agreed to begin preparing attribute sheets.

Follow-up During Current Examination

The first quarter 2008 report was not supported by an attribute sheet documenting the answer for each of the required testing elements listed in the contract. Is AGP preparing an attribute sheet for the second quarter 2008 results due July 30?

Management Comments

An attribute sheet was generated for both the 1st and 2nd quarter of 2008. The Q2 2008 attribute report is not due until July 30, 2008.

TDCI Rebuttal:

Testing of the claims payment accuracy reports revealed the plan did not maintain the testing results of each required attribute of CRA Section 2.9.m.2. (See Section VII.D.2.)

3. The provider complaint log does not include a column for resolution date therefore an average response period cannot be determined. AGP agreed to document on the log the resolution date.

Follow-up During Current Examination

The resolution date was added by AGP to the provider complaint log.

4. Remittances supporting payments of true-ups for case rates to CMHCs require enhancements since only a roster of accepted case rates are provided. AGP has agreed to include a roster of denied priority participants billed.

Follow-up During Current Examination

Is the CMHC sent rosters of denied priority participants billed with the settlement?

Management Comments

Data disks for CMHC settlements include all claims on the system. Two separate tables are prepared for the priority members included with the payments and the non-priority members excluded from the payments. This process has been in place since the second round of settlements in September 2007.

5. AGP required before the receipt of an advance payment that the provider execute an "Advance Agreement". AGP did not obtain TDCI prior approval as a material modification of AGP's Certificate of Authority before executing these agreements per Tenn. Code Ann. § 56-32-203(c)(1). The agreements should be submitted to TDCI for approval.

Follow-up During Current Examination

The Advance Agreement was later submitted by AGP and approved by TDCI.

6. From AGP's second quarter 2007 claims accuracy testing, five claims reported as properly paid were judgmentally selected from the second quarter 2007 reporting for further testing. The claims were reviewed in the claims processing system to determine if the assessment of accuracy was correct. Attributes tested included eligibility, duplicate check, agreement to fee schedule, and confirmation with the executed provider contract. No deficiencies were noted for the claims tested. As a follow-up, AGP needs to locate the fee schedule for one of the claims selected for testing.

Follow-up During Current Examination

The First Quarter 2008 Claims Payment Accuracy Report was selected for testing during the current examination. (See Section VII.D.2.)

7. For 3 of 35 paid claims selected for testing, the calculated payment for inpatient services did not agree with the recalculations based upon the diagnostic related group (DRG) method. AGP's representative determined that when AGP began operations on April 1, 2007, the loaded DRG methodology had not been updated. This situation will require recalculation for all DRG based payments made from April 1, 2007 through July 2, 2007 when AGP had loaded the update DRG methodology. AGP's representative stated that AGP would review all DRG payments to determine if any provider was over/under paid and make the necessary adjustment.

Follow-up During Current Examination

Claims have been selected for testing during the current fieldwork and the results of the testing can be found in Section C of this report.

When does AGP anticipate beginning internal projects entitled Forager to recoup overpayments?

Management Comments

AGP's Forager unit has conducted a DRG payment review for all DRG claims paid > \$0 since market "go live". The net result of these overpayments is estimated to be ~\$6M across all facilities. As a result, Forager has conducted meetings with and informed Health Plan Solutions (HPS) of the identified payment issues and their associated timeframes. HPS is currently resolving these issues to ensure consistently accurate claims payment going forward. About half of the overpayment/underpayment files are currently at the health plan for review. Immediately upon the health plan's thorough review and agreement of the files, they are ready to be shared with the facilities in order to discuss recoupment options.

8. For two of the 40 adjusted claims selected for testing AGP indicated that one service line on the two claims should not have paid upon reprocessing because of incorrect manual overrides of the claims processing system.
 - One claim incorrectly paid on adjustment for a service line for an injection code that was covered under the payment of the office visit.
 - One claim incorrectly paid on adjustment for a service line that had been previously paid and should have been denied as duplicate.

Follow-up During Current Examination

Claims have been selected for testing during the current fieldwork and the results of the testing can be found in Section VII.G and VII.H. of this report.

9. For six of the 40 adjusted claims selected for testing, an error or explanation code was not communicated in prompt pay data files provided to TDCI yet the claims processing system indicated an error or explanation code. AGP should review data extraction procedures for prompt pay testing and report the error or explanation codes in prompt pay data files provided to TDCI in the future.

Follow-up During Current Examination

Claims have been selected for testing during the current fieldwork and the results of the testing can be found in Section VII.G and VII.H. of this report.

10. The following deficiencies were found when 100 denied claims were tested:

- For two of the denied claims tested, the claims were correctly denied but the denial code communicated to the provider did not reflect the true nature of the denial. The denial code claim was N55 "History Max Lifetime Occurrence". AGP had paid for this service on a previous claim and should have instead denied as duplicate. AGP should review all denial codes and determine if they properly reflect the nature of the denial.
- For three of the denied claims tested, the error or explanation code communicated to TDCI through prompt pay testing was found to be different than the error or explanation code in AGP's claims processing system and communicated to providers. AGP should review data extraction procedures for prompt pay testing and report the correct code.
- For one of the denied claims selected for testing, the claim incorrectly denied with the explanation code YA7 "Submit Medicare claims to TN Medicaid". This code should only be communicated when coinsurance may be due from TennCare on a crossover claim. The eligibility of benefits statement from Medicare denied this service as not medically necessary. A denial reason was not communicated to the provider as to whether AGP also considered this service as not medically necessary. AGP stated they will research whether the claim should be reprocessed. AGP should review all denial codes and determine if they properly reflect the nature of the denial.
- For two of the denied claims tested, the claims on original processing denied for the reason PS1 "Exceeds the Maximum Allowable". However, the claims were reprocessed with a different denial code of B34 "Disallow Inappropriate Place of Service". During field work, AGP could not confirm the accuracy of

the denial on reprocessing and stated it will research the denial. AGP should respond if the denials were correct.

- For one of the denied claims tested, the claim was denied for the reason 073 “Deny All Claim Lines”. This denial code communicated to the provider did not reflect the true nature of the denial. An explanation of benefits from a commercial carrier was provided with the claim submission, however, the explanation of benefits is illegible. The provider does not have sufficient explanation to correct the denial. AGP stated that they will research to determine the proper denial. AGP should review all denial codes and determine if they properly reflect the nature of the denial.
- For one of the denied claims tested, the claim denied with the code G48 “Inappropriate Billing for the Contract”. This denial code communicated to the provider did not reflect the true nature of the denial. AGP agreed that the claim incorrectly denied and AGP reprocessed the claim for payment on August 29, 2007. AGP should review all denial codes and determine if they properly reflect the nature of the denial.

Follow-up During Current Examination

Claims have been selected for testing during the current fieldwork and the results of the testing can be found in Section VII.G and VII.H. of this report.

D. Claims Payment Accuracy Reports

Section 2-9.b. of the West Tennessee CRA and Section 2.22.6 of the Middle Tennessee CRA require that 97% of claims are paid accurately upon initial submission. AGP is required to submit quarterly a claims payment accuracy report 30 days following the end of each quarter.

For the TLC operations in the West Tennessee Grand Region, the following results were reported for claims payment accuracy testing for the examination period. It should be noted that AGP purchased TLC on November 1, 2007.

West Tennessee	Results Reported	Compliance
Second Quarter 2007	97%	YES
Third Quarter 2007	89%	NO
Fourth Quarter 2007	95%	NO
First Quarter 2008	96%	NO

AGP's TLC operations failed to comply with Section 2-9.b. of the West Tennessee CRA which requires that 97% of claims are paid accurately upon initial submission for the third and fourth quarter 2007 and the first quarter 2008.

Management Comments

Management concurs.

For AGP's TennCare operations for the Middle Tennessee Grand Region, the following results were reported for claims payment accuracy testing for the examination period.

Middle Tennessee	Results Reported	Compliance
Second Quarter 2007	91%	NO
Third Quarter 2007	92%	NO
Fourth Quarter 2007	94%	NO
First Quarter 2008	87%	NO

AGP failed to comply with Section 2.22.6 of the Middle Tennessee CRA which requires that 97% of claims are paid accurately upon initial submission for the second, third, and fourth quarter 2007 and the first quarter 2008.

Management Comments

Management concurs.

1. Procedures to Review the Claims Payment Accuracy Reports

The review of the claims payment accuracy reports included an interview with responsible staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy reports. The review included verification that the number of claims selected by AGP agreed to requirements of Section 2-9.m.2. of the West Tennessee CRA and Section 2.22.6.4 of the Middle Tennessee CRA. These interviews were followed by a review of the supporting documentation used to prepare the First Quarter 2008 reports for West and Middle Tennessee. For the TLC-West Tennessee operation, five claims reported as errors and ten claims reported as accurately processed were selected for verification by TDCI. For AGP's Middle Tennessee operations, all claims reported as errors and ten claims reported as accurately processed were selected for verification by TDCI. For claims that were considered errors, testing focused on the type of error (manual or system) and whether the claim was reprocessed. For claims that were reported as accurately processed by AGP, TDCI tested these claims to the attributes required in Section 2-9.m.2. of the West Tennessee CRA and Section 2.22.6.4 of the Middle Tennessee CRA.

2. Results of the Review of the Claims Payment Accuracy Reporting

AGP's TLC West Tennessee Operations

For the claims selected for verification by TDCI from the first quarter 2008 claims payment accuracy report, TDCI agrees with the results reported by AGP. However, the following deficiency was noted during the review of the procedures to prepare claims payment accuracy reports.

- Procedures for testing Claims Payment Accuracy are deficient because the plan did not maintain the testing results of each required attribute. Section 2.9.m.2 of the CRA requires:

For audit and verification purposes, the population of claims should be maintained. Additionally, the results of testing at a minimum should be documented to include...Results for each attribute tested for each claim selected.

Management Comments

Management concurs with this finding. As of the date notified by TDCI of this requirement, AGP's TLC operations maintained claim payment accuracy attribute results so as to be in compliance with Section 2.9.m.2 of the CRA.

AGP's Middle Tennessee Operations

For the claims selected for verification by TDCI from the First Quarter 2008 Claims Payment Accuracy report, TDCI agrees with the results reported by AGP. However, the following deficiency was noted during the review of the procedures to prepare claims payment accuracy reports.

- Procedures for testing Claims Payment Accuracy are deficient because the plan did not maintain the testing results of each required attribute. Section 2.22.6.4 of the CRA requires:

For audit and verification purposes, the population of claims should be maintained. Additionally, the results of testing at a minimum should be documented to include...Results for each attribute tested for each claim selected.

Management Comments

AGP's independent Internal Audit function concurs with this finding. As of the date that AGP's Independent Internal Auditor was notified by TDCI of this requirement, claim payment accuracy attribute results have been maintained in compliance with Section 2.22.6.4 of the CRA. It should be noted that AGP's non-

independent Quality Assurance department was maintaining claim payment accuracy attribute results as required.

3. Additional Analysis of Error Claims – AGP’s Middle Tennessee Operations

Contractor Risk Agreement Section 2.30.15.1 requires AGP to achieve a 97% claims payment accuracy percentage. AGP has not achieved 97% claims payment accuracy since implementation on April 1, 2007. AGP reported for the first quarter 2008 a claims payment accuracy percentage of 87%. The accurate payment of provider medical claims is critical to the stability of the TennCare program. TDCI and the Comptroller performed additional testing of the error claims noted in AGP’s Middle Tennessee Claims Accuracy reports for the First Quarter 2008. The following is a summary and analysis of the types of errors noted:

- The single issue that resulted in the largest number of errors (11 of 38) in the First Quarter 2008 report was identified by AGP as provider selection error. Procedures and system configurations for both paper and electronic claims have failed to always identify the correct “pay to” provider. This type of error has occurred since implementation on April 1, 2007. AGP’s attempt to correct these errors through system enhancements in the fourth quarter 2007 failed. AGP is attempting additional enhancements to the system to improve the accuracy of provider selection and has targeted July 31, 2008 for the enhancement completion. This issue has remained unresolved for too long. Alternate procedures should have been developed to proactively search out these errors before processing and payment. It is most likely this issue will continue at a similar level resulting in the failure of the claims payment accuracy requirement for the second quarter 2008. AGP should develop contingency plans to address the issue in case the enhancement targeted for July 31, 2008 fails.

Management Comments

Management concurs with the findings, however it should be noted that since March 2009 AGP has met or exceeded the 97% requirement for claim payment accuracy. All planned modifications to AGP’s provider selection logic mentioned above were completed and are in production, including an additional set of logic that was installed in December 2008 to further improve provider selection logic.

- Seven of the 38 errors can be attributed to delays by AGP in loading CMS updates to provider payment configurations. Payment to most of AGP providers is a factor of CMS payment rates. AGP’s provider contracts require AGP to timely update provider payment configurations whenever updates are made by CMS. The health plan in Tennessee relies solely on Provider Information Management (PIM), a division of the parent corporation, to

update provider payment configurations. PIM admits procedures to update fee schedules were not timely and during the first quarter 2008 PIM has updated workflows to promptly recognize changes by CMS and update AGP's provider payment configurations. The new procedures developed by PIM should prevent these errors in the future.

Management Comments

Management concurs and has instituted new processes to manage updates to its CMS based fee schedules. Since these new processes were created AGP has experienced minimal claim payment accuracy issues related to fee schedule maintenance.

- Two of the 38 errors were the result of an unauthorized change to a single provider payment configuration by PIM. As a result, claims payments to the provider were inaccurately paid and required reprocessing. Disturbing to TDCI is how controls failed to prevent the unauthorized change. Any add, change, or deletion to provider payment configurations can affect thousands of claims. Sufficient internal controls over provider payment rate configurations would "lock down" and prevent changes to configurations that are paying correctly. Any change to configurations should require sign off by multiple levels of PIM personnel as well as health plan officials.

Management Comments

Management concurs and has instituted new controls that require approval of personnel both at the health plan (2 different levels of sign off) and additional sign off from support personnel are required before implementing a change in a provider's payment configuration.

- Seven of 38 errors were caused by the provider payment configuration not matching the terms of the provider contract. For these error claims either the provider was assigned to the wrong fee schedule or an allowable procedure was billed but pricing had not been established. As of the May 2008 site visit, AGP indicated a full audit of all provider payment configurations was in the planning phases but the scope of the audit had not been developed. TDCI encourages a speedy but thorough audit of the provider payment configuration. However, AGP must also analyze why fee schedules were improperly assigned to providers. Procedures by both health plan officials and PIM must ensure that adds, changes, or deletions to provider payment configuration are tested and then confirmed once placed in production. AGP provided the following additional response in regards to their auditing efforts:

The audit includes the following areas of focus and we anticipate the audit being substantially complete by the end of July, with all work anticipated to be complete by August or early September (2008). The

focus of this audit is our Health Plan Services (HPS) groups work, which includes PIM.

- Fee Schedule verification - verification of all fee schedule information and its accuracy
- Agreement Assignment Verification - verification that all pricing agreements are correctly assigned to the right provider ID
- Verification that all DRG rates are properly setup and assigned by hospital
- Remediation of all agreement audit findings above
- Increased usage of Networx Pricer, an additional pricing module within Facets that offers more flexibility with configuration to automate difficult reimbursement arrangements currently handled manually today. Also supports more automation of provider configuration.
- Provider outreach to validate provider demographics on file
- Demographic quality review and remediation
- Validation of all manual claim instructions (SPI's)

Management Comments

Management concurs. During the 2nd half of 2008 and 1st quarter of 2009 AGP conducted a complete audit of the configuration of its provider agreement configuration in its system back to the actual signed agreement. Any variation was noted and corrected in this rigorous process and the result of this activity is validated by our meeting or exceeding the claim payment accuracy results since March 2009.

- The remaining errors in the First Quarter 2008 claims payment accuracy reports were the result of human intervention, such incorrect member selection, anesthesia claims pricing, and application of plan benefits.

Management Comments

Management concurs. AGP has conducted additional training for the claims analyst. We also conducted focus audits to identify area that needed improvements. As a result of the audits, action plans were initiated for the staff that required additional assistance. In the month of March 2009, AGP moved 5 analysts to a different market that better fit their skills.

E. Claims Selected For Testing From Prompt Pay Data Files

Medical claims for enrollees in the Middle Tennessee Grand Region are processed by the parent of AGP, AMERIGROUP Corporation. Vision claims for enrollees in the Middle Tennessee Grand Region are processed by the subcontractor, Block Vision. Medical and vision claims for enrollees in the West Tennessee Grand Region are

processed by AGP's TLC-West Tennessee operations in the office in Memphis, Tennessee.

TDCI utilized the February and March 2008 claims data files previously submitted by AGP for prompt pay compliance to select claims for testing. For each claim processed, the data files included the date received, date paid, the amount paid, and if applicable, an explanation for denial of payment. To ensure that the February 2008 and March 2008 data files included all claims processed in the month, the total amount paid per the data files was reconciled to the triangle lags within an acceptable level.

The claims judgmentally selected for testing by TDCI included, but were not limited to, high dollar paid claims, claims with the top occurring denial reasons, and adjusted claims. The number of claims selected for testing was not determined statistically. The results of testing are not intended to represent the percentage of compliance or non-compliance for the total population of claims processed by AGP.

The following represents the total number of claims selected for testing by processor:

- 115 - AGP's Middle Tennessee Operations
- 60 – AGP's TLC-West Tennessee Operations
- 10 – Subcontractor Block Vision

F. Comparison of Actual Claim with System Claim Data

The purpose of this test is to ensure that the information submitted on the claim was entered correctly in AGP's claims processing system. The CRA requires minimum data elements to be recorded from medical claims and submitted to TennCare as encounter data. Additionally, TDCI receives monthly claims with selected data elements in order to determine compliance with prompt payment requirements. The data elements recorded on the claims for testing was compared to the data elements entered into AGP's claims processing system and data elements provided by the plan to TDCI for prompt pay testing.

No discrepancies were noted in the 115 claims processed by AGP's Middle Tennessee operations when comparing the data elements on the claim to information entered into the claims processing system.

No discrepancies were noted in the 60 claims processed by TLC-West Tennessee operations when comparing the data elements on the claim to information entered into the claims processing system.

For one of the 10 claims selected for testing from claims processed by Block Vision, a rejected service line of the claim was not included in the prompt pay file submitted to TDCI. All processed service lines should be included in the prompt pay data files.

Management Comments

Management concurs. AGP has been working with Block Vision to improve the accuracy of its prompt pay data files to TDCI.

G. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected.

AGP's Middle Tennessee Operations

For 14 of the 115 claims selected for testing from claims processed by AGP's Middle Tennessee operations, the following adjudication errors were discovered:

- One medical health claim was denied with the incorrect denial reason "reduced allowable". The explanation reason should have been the explanation of benefits provided was illegible.
- One medical health claim was denied with the incorrect denial reason "deny all claim lines". The explanation reason should have been the explanation of benefits provided was illegible.
- One medical health claim selected for testing was not for a TennCare enrollee. The claim should not have been included in data files submitted to TDCI or in encounter data submissions to the TennCare Bureau.
- One medical health claim was incorrectly denied for one service line as invalid procedure. The procedure code submitted by the provider was valid.
- One behavioral health claim was denied with the incorrect denial reasons of "inappropriate billing for this contract" and "primary carrier information required". The explanation reasons communicated to the provider should have been "paid under bi-weekly settlement" and "covered under case rate".
- One medical health claim was denied with the incorrect denial reason "lack of modifier. The provider had correctly submitted a modifier on the claim.
- One medical health claim was denied with the incorrect denial reason "history maximum". The explanation reason communicated to the provider should have been the claim is a duplicate of a previously submitted claim.

- One behavioral health claim was denied with the incorrect denial reason “agreement discount”. The service line should have been denied as “not a covered service”. A second service line on the claim was incorrectly denied with the explanation reason of “not a covered service”. The service line submitted was a covered service.
- One behavioral health claim was incorrectly denied as not a covered service. The claim was for valid covered services.
- One behavioral health claim was denied with the incorrect denial reason “billing error”. The claim did not contain billing errors and the explanation reasons communicated to the provider should have been “paid under bi-weekly settlement” and “covered under case rate”.
- One behavioral health claim was incorrectly denied with the explanation reason of “preauth not obtained”. A preauthorization was not required. The explanation reasons communicated to the provider should have been “paid under bi-weekly settlement” and “covered under case rate”.
- One behavioral health claim was incorrectly paid for a service line for a procedure not covered under the provider’s contract. A second service line on the claim was incorrectly denied with the explanation reason “not a covered service”. The service line submitted was for a covered service.
- Two behavioral health claims reported with service lines having a denied status in test data files submitted to TDCI for prompt pay testing. For these service lines, the reported status should be capitated because they represented services covered under a bi-weekly service.

Management Comments

Management concurs with all of the above comments with the exception of (one) claim. Claim processed with the correct denial reason code as per our claims editing tool (Claim Check). All other claims have been reprocessed accordingly.

AGP’s TLC West Tennessee Operations

For eight of the 60 claims selected for testing from claims processed by AGP’s TLC-West Tennessee operations, the following adjudication errors were discovered:

- One medical health claim was incorrectly denied for other insurance (CIGNA). The claim processing system indicates that the enrollee did not have other insurance on the date of service.

TLC Management Comments

The claim was denied correctly on 3/10/08 based on the eligibility data received from the State at the time the claim was processed. An eligibility update was received from the State on 6/17/08 and updated on 6/18/08 showing that other coverage was terminated on 8/6/2007. There is not an automatic individual claims analysis performed with each State tape up-date to search for prior denied claims. The Claims appeal process must be followed in order for an individual claim to be reprocessed due to an eligibility update. The claim was not reprocessed because there is no record of an appeal on file from the provider.

- One medical health claim was incorrectly denied for other insurance (Blue Cross). The claim processing system indicates that the enrollee did not have other insurance on the date of service.

TLC Management Comments

The claim was denied correctly on 3/10/08 based on the eligibility data received from the State at the time the claim was processed. An eligibility update was received from the State on 4/23/08 and updated showing that other coverage was terminated on 10/01/2007. There is not an automatic individual claims analysis performed with each State tape up-date to search for prior denied claims. The Claims appeal process must be followed in order for an individual claim to be reprocessed due to an eligibility update. The claim was reprocessed because the claim was appealed in the form of a resubmission from the provider.

- One medical health claim was incorrectly denied with the explanation reason of "NDC# IS INCORRECT OR INVALID". Per the information submitted on the electronic claim a valid NDC number was submitted with the claim.

TLC Management Comments

Although the NDC number was present on the edit file, the NDC number was not updated in our system (NDCCD) until 03/08/08 and this claim was processed on 03/04/08.

- One medical health claim was incorrectly denied with the explanation reason "PROCEDURE CODE NOT INCLUDED IN PROVIDER CONTRACT". The claim should have denied "No Authorization".

TLC Management Comments

TLC agrees that an incorrect denial code was used. However, the incorrect denial code did not produce an underpayment of the claim.

- One medical health claim was incorrectly denied with the explanation reason “CCSRV”. The explanation reason is an internal denial code used by the plan and does not communicate to the provider why the claim was denied. Claims should not be denied with internal denial codes and the claim system should be reviewed to ensure continuous billing claims are adjudicated properly.

TLC Management Comments

Original claim never hit a hold. Claim denied CCSR because it could not price based billed type (114). We have edits in place to generate a ‘CCSRV’ report so that no claim goes out with that denial reason, and it is worked by Claims and BA’s. Appears to be human error, this claim went to check before the report was worked in its entirety.

- One medical health claim was reprocessed but no documentation could be found as to why the claim was reprocessed.

TLC Management Comments

This was an EDI claim denied on 2/11/08 for incorrect authorization or auth submitted does not match. The note in the Diamond note field says that the auth# did not match the member. The claim was reprocessed with the correct auth number by a Claims Review Representative who handles this provider’s accounts and appeals. It appears that this appeal could have come in directly by phone to the CRR for handling.

- One medical health claim incorrectly paid on resubmission. The claim should have denied since the provider failed to obtain a prior authorization.

TLC Management Comments

The claim (99922070) denied as duplicate because the provider re-submitted the claim electronically instead of submitting as an appeal including the Authorization number. The claim was adjusted on 01/14/08 (99922070A) because the provider submitted an appeal and claim number 99922070 reflected the auth number was submitted. TLC discovered we had system issues with the new authorization project that had been implemented in November. TLC re-processed all affected claims and this claim was included in the re-processing; TLC turned off TIME and DUPLICATE rules to re-process all affected claims.

- One medical health claim was incorrectly paid to the wrong provider.

TLC Management Comments

This claim is part of a larger EDI project for this provider who submitted several large EDI files under the incorrect provider ID#. The project is not completed as

of this date [August 25, 2008]. EDI and Provider Relations are still working with this provider to correct their submission before the claims are reprocessed.

Vision Subcontractor – Block Vision

No adjudication discrepancies were noted for the 10 claims selected for testing from claims processed by Block Vision.

H. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts are calculated correctly.

AGP's Middle Tennessee Operations

No pricing accuracy errors were noted for any of the 115 claims selected for testing from claims processed by AGP's Middle Tennessee operations.

AGP's TLC West Tennessee Operations

For five of the 60 claims selected for testing from claims processed by AGP's TLC-West Tennessee operations, the following pricing accuracy errors were discovered:

- One medical health claim was paid incorrectly for a specific revenue code. The claim should have paid based on contractual terms of 67.5 % of billed charges.

TLC Management Comments

Claim paid incorrectly due to set up error on price rule BK. This has been corrected.

- One medical health claim was paid incorrectly on first submission using a methodology based on level of services for ambulatory service centers. The claim should have been paid on contractual terms of 52.5% of billed charges.

TLC Management Comments

Claim auto adjudicated. Priced incorrectly due to missing service reason, should have had service reason OPSXX on header. Appears claim did not go through the automated pre-processor. Outpatient claims entered with service reason OPSXX will price at 52.5% of billed.

- One medical health claim was paid incorrectly. Procedure code 77280 paid \$158.56. However, this procedure should have paid \$122.55.

TLC Management Comments

Code 77280 – The correct amount is \$122.55. Institutional provider paid on TC component only. Technical component has a RVU of 3.2653 x 37.53 per unit = \$122.55. Claim originally paid full component 4.225 x 37.53 = \$158.56. Appears price rule was corrected.

- One medical health claim was underpaid by \$4.27. The claim should have paid based on contractual terms of 52.5 % of billed charges.

TLC Management Comments

This claim held for many reasons, and the incorrect service was used on the header, so automatic pricing could not work. Total charges \$14,993.56; total ELIGIBLE charges is \$14,984.56 (\$14,993.56 – \$9.00: line 007 billed for venipuncture) making the total eligible charge \$14,984.56 x 52.5% = 7866.89. Manually calculated incorrectly.

- One medical health claim incorrectly priced a service line based on 42.5% percent of billed charges. The claim should have paid instead based on a fee schedule.

TLC Management Comments

Provider set up has been corrected and code pays at fee schedule now.

Vision Subcontractor – Block Vision

No pricing errors were noted for the 10 claims selected for testing from claims processed by Block Vision.

I. Copayment Testing

The purpose of copayment testing is to determine whether copayments have been properly applied for enrollees subject to out-of-pocket payments.

TDCI requested a listing of 100 enrollees with the highest accumulated copayments assessed for the period April 1, 2007, through December 31, 2007 for AGP's Middle Tennessee operations. Five of the enrollee's claims from the listed were reviewed through the claims processing system for the accurate application of copayment requirements. No discrepancies were noted.

J. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system.

For AGP's TLC-West operations, eight remittance advices (referred to as "EOP" by the plan) were selected for testing related from the 60 claims selected by TDCI for testing. The remittance advices reviewed reflected the processed claim information in the AGP's claims processing system.

For AGP's Middle Tennessee operations, five remittance advices (referred to as "EOP" by the plan) were selected for testing related to the 115 claims selected by TDCI for testing. The remittance advices reviewed reflected the processed claim information in the AGP's claims processing system.

K. Analysis of Cancelled Checks

The purpose of analyzing cancelled checks is to: (1) verify the actual payment of claims by AGP; and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

For AGP's TLC-West operations, eight cancelled checks were selected for testing from the 60 claims selected by TDCI for testing. Actual payments were verified and no significant lag existed between the issue date and the cleared date of the cancelled checks tested.

For AGP's Middle Tennessee operations, five cancelled checks were selected for testing from the 115 claims selected by TDCI for testing. Actual payments were verified and no significant lag existed between the issue date and the cleared date of the cancelled checks tested.

L. Pended and Unpaid Claims Testing

The purpose of analyzing pended claims is to determine if a significant number of claims are unprocessed and as a result a material liability exists for the unprocessed claims.

The pended and unpaid data files submitted to TDCI as of November 30, 2007, were reviewed for claims which exceeded 60 days old. The pended and unpaid data files for West and Middle Tennessee processed by AGP indicate only 16 claims exceeded 60 days in process. No material liability exists for claims over 60 days.

M. Mailroom and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls is to determine if procedures by AGP ensure that all claims received from providers are

either returned to the provider where appropriate or processed by the claims processing system. The review of mailroom and claims inventory controls included a walk through with mailroom and claims processing personnel. Based on the review, controls in the mailroom and claims inventory controls were adequate.

For testing of the accurate received dates in the claims processing system, TDCI selected for testing ten medical claims received in AGP's mailroom. Verification later in the claims processing system found that accurate received dates were recorded for the seven claims entered into the claims system. Three of the ten claims were returned to the provider because the claims were not enrollees of AGP.

VII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints

Provider complaints were tested to determine if AGP responded to all provider complaints in a timely manner. Tenn. Code Ann. § 56-32-126 states:

The health maintenance organization must respond to the reconsideration request within thirty (30) calendar days after receipt of the request. The response may be a letter acknowledging the receipt of the reconsideration request with an estimated time frame in which the health maintenance organization will complete its investigation and provide a complete response to the provider. If the health maintenance organization determines that it needs longer than thirty (30) calendar days to completely respond to the provider, the health maintenance organization's reconsideration decision shall be issued within sixty (60) calendar days after receipt of the reconsideration request, unless a longer time to completely respond is agreed upon in writing by the provider and the health maintenance organization.

AGP's TLC West Tennessee Operations

For AGP's TLC West Tennessee operations, policies and procedures were in compliance with Tenn. Code Ann. § 56-32-126.

Five provider complaints were selected for testing. All five complaints were resolved within 30 days. However, for one complaint tested, the plan correctly denied a claim for lack of prior authorization. After submission as a provider complaint, the provider obtained the authorization from the plan. Upon resubmission, the plan incorrectly denied the claim for timely filing.

Management Comments

Management concurs.

AGP's Middle Tennessee Operations

For AGP's Middle Tennessee operations, policies and procedures were not in compliance with Tenn. Code Ann. § 56-32-126 during the examination period. Policies and procedures for the plan did not require a response to reconsideration request within 30 calendar days. TDCI noted that the policies and procedures were updated before fieldwork in July 2008 to comply with Tenn. Code Ann. § 56-32-126.

Management Comments

Management Concur

TDCI selected provider complaints received by the plan in March 2008 to test. AGP maintains two logs which records provider complaints. Complaints from the "Appeal Log" and the "March 2008 Complaint Log" were reviewed for responses by the plan to the provider exceeding 30 and 60 days. The response by AGP to twelve complaints exceeded 30 days and one complaint exceed 60 days in violation of Tenn. Code Ann. § 56-32-126. For the twelve responses that exceeded a 30 day deadline, no acknowledgement was communicated to the provider that the response would exceed 30 days. For the one response that exceeded a 60 day deadline, no agreement was made in writing to the provider noting that the response would exceed 60 days.

Management Comments

Management concurs. Extension letter was implemented in September 2008.

From the test month of March 2008, TDCI selected twelve complaints for further testing. The complaints were reviewed by testing source documents and reviewing the results of claims processing related to the complaint. For eight of the twelve complaints tested, the date in the claims processing system for the "remit date" or the "resolution" date did not match the "End Date" or "Response Date" on the complaint log. The plan must ensure the complaint logs correctly report resolution or response dates to ensure compliance with Tenn. Code Ann. § 56-32-126.

Management Comments

Management concurs.

B. Provider Manual

The provider manual outlines written guidelines to providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim.

For AGP's TLC West Tennessee operations, the provider manual was approved August 2006 and agrees with the version communicated to providers.

For the AGP's Middle Tennessee operation, the following deficiencies were noted in the review of the provider manual:

- The provider manual was approved by TDCI on January 2007, however the version communicated to providers on the company website does not agree with the approved version.
- On the company website, providers were informed of 36 updates to the provider manual as of July 2008. These updates to the provider manual should be submitted as material modifications to operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1).
- All of AGP's provider agreements incorporate by reference the requirements of the provider manual. Any amendment to the provider manual would require AGP to notify providers of amendments to the provider manual. Section 2.12.7.35 of the Middle Tennessee CRA:

Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the provider agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the provider agreement, then the terms must include provisions allowing at least thirty (30) calendar days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., certified mail, facsimile, hand-delivered receipt, etc);

Eleven provider agreements were tested to determine if AGP complied with the notification requirements of the CRA for amendments to the provider manual. None of the eleven provider agreement files selected for testing contained evidence of compliance with notification requirements.

Management Comments

Management concurs with the findings and has instituted new processes to ensure that communications updating the Provider Manual are approved by TDCI prior to distribution and that these materials are distributed to providers in accordance with §2.12.7.35 of the CRA.

C. Provider Agreements

Agreements between an HMO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of

authority for a company to operate as an HMO as provided by Tenn. Code Ann. § 56-32-103(b)(4). The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-103(c)(1). Additionally, the TennCare Bureau has defined through contract with the HMO minimum language requirements to be contained in the agreement between the HMO and medical providers. These minimum contract language requirements include, but are not limited to, standards of care, assurance of TennCare enrollees' rights, compliance with all federal and state laws and regulations, and prompt and accurate payment from the HMO to the medical provider.

Five provider agreements for AGP's TLC West Tennessee operations were selected for testing by TDCI. All of the contracts included amendments through the most recently approved material modifications prior approved by TDCI. TLC maintained documentation that the most recent amendment was sent to each of the providers tested.

Twelve provider agreements for AGP's Middle Tennessee TennCare operations were selected for testing by TDCI.

TDCI approved on September 17, 2007 amended provider agreement templates submitted by AGP. As of fieldwork in July 2008, ten of the twelve provider agreements selected have not been executed on the amended provider agreement templates approved on September 17, 2007. Additionally, all twelve executed provider agreements were deficient since they did not include the amended provider agreement language requirements of the CRA. AGP should develop procedures to promptly amend provider agreements when amendments to the CRA update provider agreement language requirements.

Management Comments

Management concurs.

D. Provider Payments

Capitation payments to providers were tested to determine if AGP complied with the payment provisions set forth in its capitated provider agreements. Review of payments to capitated providers indicated that all payments were made per the provider contract requirements in a timely manner. In conjunction with testing of the Medical Loss Ratio reports, provider payments on a per member per month basis were tested for the month of March 2008. Payments were made in accordance with terms of the tested provider agreements.

E. Subcontracts

HMOs are required to file notice and obtain the Commissioner's approval prior to any material modification of operational documents in accordance with Tenn. Code Ann. § 56-32-103(c)(1). Additionally, per Section 2-9. of the West Tennessee CRA and 2.26.3 of the Middle Tennessee CRA, all template subcontractor agreements and revisions thereto must be approved in advance in writing by TDCI, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof.

A subcontract for transportation services was selected for testing for AGP's TLC-West Tennessee operations. The subcontract was executed on a subcontract and an ancillary provider agreement template approved in advance by TDCI.

Four subcontracts for AGP's TennCare operations in Middle Tennessee were selected for testing for the services:

- Vision services
- Nurse help line services
- Claims processing and third party liability recovery services
- Transportation services

.All four contracts were approved in advance in writing by TDCI.

F. Non-discrimination

Section 2-24. of the West Tennessee Grand CRA and Section 2.28 of the Middle Tennessee CRA require AGP to demonstrate compliance with Federal and State regulations of Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age of Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981. Based on discussions with various AGP staff and a review of policies and related supporting documentation, AGP was in compliance with the reporting requirements of Section 2-24. of the West Tennessee Grand CRA and Section 2.28 of the Middle Tennessee CRA.

G. Internal Audit Function

The importance of an internal audit function is to provide an independent review and evaluation of the accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. An internal audit function is responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. The internal audit department should report directly to the board of directors so the department can maintain its independence and objectivity.

TDCI had previously communicated to AGP that internal audit should be responsible for the performance of claims payment accuracy testing requirements of Section 2-9.m.2. of the West Tennessee CRA and Section 2.22.6.4 of the Middle Tennessee CRA. AGP's TLC-West Tennessee operations complied with this provision; however operations for the Middle Tennessee Grand Region did not have an internal auditor prepare the claims payment accuracy reports. AGP satisfactorily corrected this deficiency for the first quarter 2008 claims payment accuracy reporting by requiring an internal auditor from TLC review the claims payment accuracy testing.

H. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., Title 56, Chapter 11, – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-105 states, “Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner....”

AGP has complied with the requirements of the Holding Company System Act of 1986.

I. Behavioral Health Organization (BHO) Coordination

Effective July 1, 2002, Section 2-3.c.2. of the Middle Tennessee CRA states that claims for covered services with a primary behavioral diagnosis code, defined as ICD 9-CM 290.xx- 319.xx, are submitted to AGP for timely processing and payment. AGP is required to refer unresolved disputes between the HMO and BHO to the State for a decision on responsibility after providing medically necessary services. TLC-West Tennessee operations did not have any ongoing disputes with the BHO. As previously noted for the Middle Tennessee Grand Region, the CRA requires AGP to provide both medical and behavioral health services.

J. Contractual Requirements for ASO Arrangements

As previously mentioned, effective July 1, 2002, the West Tennessee CRA was amended so that the TLC TennCare operations would operate as an ASO. As a result, the provisions tested below are requirements for transactions with dates of service on and after July 1, 2002.

1. Medical Management Policies

Section 3-10.h.2(a) of Amendment 4 to AGP's West Tennessee CRA requires AGP to comply with the following:

The CONTRACTOR shall reimburse providers according to reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures in effect as of April 16, 2002, for covered services as defined in Section 3-10.h.2(j), unless otherwise directed by TENNCARE, with funds deposited by the State for such reimbursement by the CONTRACTOR to the provider.

AGP's management has confirmed compliance with the requirements described above. During testing of claims processing and provider contracts, no deviations to the requirement were noted.

2. Provider Payments

Section 3-10.h.2(b) of the West Tennessee CRA states AGP "shall release payments to providers within 24 hours of receipt of funds from the State." Based on TDCI's review, AGP has complied with this provision.

3. 1099 Preparation

Section 3-10.h.2.(c) of the West Tennessee CRA states that AGP "shall prepare and submit 1099 Internal Service Reports for all providers to whom payment is made." Based on TDCI's review, AGP has complied with this requirement.

4. Interest Earned on State Funds

Section 3-10.h.2(d) of the West Tennessee CRA states interest generated by funds on deposit for provider payments related to the non-risk agreement period shall be the property of the State. The interest amount earned on the funds reported on TLC's monthly bank statement should be deducted from the amount of the next remittance request from the TennCare Bureau. Based on TDCI's review, AGP has complied with this requirement.

5. Recovery Amounts/Third Party Liability

Sections 3-10.h.2(f) and (g) of the West Tennessee CRA require third party liability recoveries and subrogation amounts related to the non-risk agreement period be reduced from medical reimbursement requests of the TennCare Bureau. As third party liability and subrogation amounts are recovered, AGP should reduce the next medical reimbursement request to the TennCare Bureau for the amounts recovered. A review of selected subrogation recoveries found that the amounts recovered were promptly recorded in the claims processing system, thereby reducing future medical reimbursement requests to the TennCare Bureau.

6. Pharmacy Rebates

Section 3-10.h.2(f) of the West Tennessee CRA states that pharmacy rebates collected by AGP shall be the property of the State. The contract for pharmacy related services ended June 30, 2003. During the previous exam, AGP indicated no further amounts were expected for pharmacy rebates.

K. Contract to Audit Accounts

AGP is required to submit annual audited financial statements by May 1 for the preceding calendar year. Section 2-10.h.4. of the West Tennessee CRA and Section 2.21.10.2 of the Middle Tennessee CRA require such audits to be subject to prior approval of the Comptroller of the Treasury and to be submitted on the standard "Contract to Audit Accounts" agreement. The "Contract to Audit Accounts" between the Comptroller of the Treasury and the external auditor defines the standards for which the audits are to be performed. AGP has not complied with this provision for audited financial statements for the period ending December 31, 2007. AGP should ensure that their external auditor properly executes the "Contract to Audit Accounts" before each engagement.

Management Comments

AGP has properly executed a Contract to Audit Accounts for the period ending December 31, 2009.

L. Conflict of Interest

Section 4-7. of the CRA for the West Tennessee CRA and Section 4.19 of the Middle Tennessee CRA warrant that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to AGP in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

Conflict of interest requirements of the CRAs were expanded to require an annual filing certifying that the MCO is in compliance with all state and federal laws relating to conflicts of interest and lobbying.

Failure to comply with the provisions required by the CRAs shall result in liquidated damages in the amount of one hundred ten percent (110%) of the total amount of compensation that was paid inappropriately and may be considered a breach of the CRA.

The MCO is responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and for

including the substance of the CRA's conflict of interest clauses in all subcontracts, provider agreements and any and all agreements that result from the CRA.

Testing of conflict of interest requirements of the CRA noted the following:

- The most recently approved provider agreement templates contain the conflict of interest language of the CRAs.
- AGP has written conflict of interest policies and procedures in place.
- The written policies and procedures outline steps to report violations.
- Employees complete conflict of interest certificates of compliance annually per the written policy and procedures.

TDCI noted that review of reports prepared by AGP's Internal Audit department does not specifically test Conflict of Interest Provisions of the CRA. AGP responded:

Internal Audit performs an annual review of Political Contributions at the request of AMERIGROUP's Audit Committee. The scope of this review includes political campaign contribution record keeping, disbursement and monitoring procedures to ensure compliance with State and Federal election laws, as well as with AMERIGROUP corporate policy. The review covers political contributions made by AMERIGROUP, AMERIGROUP PAC, and AMERIGROUP associates from July 1 of the prior year to June 30 of the current year. Embedded within this is coverage for lobbyist activities to assure compliance with applicable laws and AMERIGROUP's policies.

TDCI recommends the annual review of Political Contributions incorporate and document specifically the Conflict of Interest provisions of the CRA.

Management Comments

We concur that Internal Audit does not perform an annual review for compliance with the conflict of interest provisions of the TN CRA. It is Internal Audit's general practice to provide coverage for state specific requirements during a review of Health Plan operations (e.g. a review of the TN Health Plan) or reviews of corporate processes where there is critical linkage to the Health Plan. However, Health Plan operations and corporate process reviews are performed on a rotational basis that does not provide coverage for the referenced contract provision on an annual basis. Additionally, the Political Contributions review is performed to meet requirements of the Audit Committee of AMERIGROUP's Board of Directors. We believe a separate annual review that focuses on the contract provisions of the CRA would be an enhancement. As such, starting with 2009, the Director, Provider Audit, who reports to the Chief Risk Officer, will perform an annual review for compliance with the Conflict of Interest Provisions of the TN CRA.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of AGP.