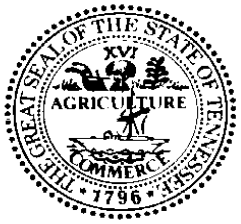

STATE OF TENNESSEE

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

THE TENNCARE OPERATIONS

OF

AMERIGROUP TENNESSEE, INC.

NASHVILLE, TENNESSEE

FOR THE PERIOD JANUARY 1, 2012
THROUGH DECEMBER 31, 2012

TABLE OF CONTENTS

STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
TENNCARE DIVISION
500 JAMES ROBERTSON PARKWAY, 11th Floor
NASHVILLE, TENNESSEE 37243-1169
615-741-2677
Phone
615-532-8872
Fax

TO: Julie Mix McPeak, Commissioner
Tennessee Department of Commerce and Insurance

Darin Gordon, Deputy Commissioner
Tennessee Department of Finance and Administration, TennCare Bureau

VIA: Gregg Hawkins, CPA, Assistant Director
Office of the Comptroller of the Treasury
Division of State Audit

Lisa R. Jordan, CPA, Assistant Commissioner
Tennessee Department of Commerce and Insurance

John Mattingly, CPA, TennCare Examinations Director
Tennessee Department of Commerce and Insurance

CC: Larry Martin, Commissioner
Tennessee Department of Finance and Administration

FROM: Gregory Hawkins, CPA, TennCare Examinations Manager
Karen Degges, CPA, Legislative Auditor
Ronald Crozier, TennCare Examiner
Laurel Hunter, CPA, TennCare Examiner
Shirlyn Johnson, CPA, TennCare Examiner
Steve Gore, CPA, TennCare Examiner

DATE: August 20, 2014

The Financial and Compliance Examination and Market Conduct Examination of the TennCare Operations of AMERIGROUP Tennessee Inc., Nashville, Tennessee, was completed July 15, 2013. The report of this examination is herein respectfully submitted.

I. FOREWORD

On April 4, 2013, 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 Financial and Compliance Examination and Market Conduct Examination of AGP's TennCare Operations. Fieldwork began on June 10, 2013, and ended on July 15, 2013.

This report includes the results of the market conduct examination "by test" of the claims processing system for AGP's TennCare operations. Further, this report reflects the results of an examination of financial statement account balances as reported for TennCare operations by AGP. This report also reflects the results of a compliance examination of AGP's policies and procedures regarding statutory and contractual requirements related to its TennCare operations. 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's TennCare operations was conducted jointly by TDCI and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller), under the authority of Section 2.25 of the Contractor Risk Agreement for the Middle Tennessee Grand Region (CRA) 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.

AMERIGROUP Tennessee, Inc. 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) Annual Statement for the year ending December 31, 2012.

The current market conduct examination by TDCI and the Comptroller focused on the claims processing functions and performance for AGP 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.

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

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; and
- Determine whether AGP had corrected deficiencies outlined in prior TDCI examinations of AGP's TennCare operations.

III. PROFILE

A. Administrative Organization

AGP was incorporated under the laws of the State of Tennessee on April 26, 2006. AGP was licensed as an HMO by TDCI 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 October 2, 2012, TDCI issued an order approving the plan of acquisition filed by WellPoint, Inc., Indianapolis, Indiana to acquire control of AGP, the Tennessee Corporation. As of December 24, 2012, the transaction to acquire AGP and AMERIGROUP Corporation by WellPoint, Inc. was completed. WellPoint, Inc., is a publicly held company trading on the New York Stock Exchange.

The officers and directors or trustees for AGP as reported on the NAIC Annual Statement for the year ending December 31, 2012, were as follows:

Officers for AGP

Alvin Brock King, President/CEO
Edna Laverne Willingham, Vice President/COO
Kathleen Susan Keifer, Secretary
Nicholas Joseph Pace, II, Vice President/Asst. Secretary
Robert David Kretschmer, Treasurer
Scott Wayne Anglin, Vice President/Asst. Treasurer

Other Officers for AGP

Kendall Benjamin Edwards, Vice President, Finance

Directors or Trustees for AGP

Charles Brian Shipp
Alvin Brock King
Wayne Scott DeVeydt
Carter Allen Beck
Catherine Irene Keleghan

B. Brief Overview

Effective April 1, 2007, AGP entered into a full-risk contract with the TennCare Bureau to provide covered TennCare benefits to enrollees in the Middle Tennessee Grand Region in exchange for a per member per month capitation payment. As of December 31, 2012, AGP had approximately 199,900 TennCare enrollees in the Middle Tennessee Grand Region. The TennCare benefits required to be provided by AGP are:

- Medical
- Behavioral health
- Vision
- Long-term care ("CHOICES" program)
- Non-emergency transportation services

In addition to TennCare operations, in January 2008, AGP began offering a Medicare Advantage Special Needs Plan for those who are eligible for both Medicaid and Medicare. For the year ending December 31, 2012, AGP had approximately 3,700 Medicare enrollees in the Middle Tennessee Grand Region.

C. Claims Processing Not Performed by AGP

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. (Block Vision) for vision services
- Tennessee Carriers, Inc. (TNC) for non-emergency medical transportation services (NEMT)

Because the TennCare Bureau has contracted with other organizations for the provision of dental and pharmacy benefits, AGP is not responsible for providing these services to TennCare enrollees.

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

No reportable deficiencies were noted during performance of financial analysis procedures.

B. Claims Processing Deficiencies

1. AGP's subcontractor, Tennessee Carriers, was not in compliance with prompt pay claims processing requirements of Tenn. Code Ann. § 56-32-126(b)(1) for non-emergency transportation claims for the month of June 2012.

   (See Section VI.A. of this report)

2. AGP was not in compliance with Section 2.22.6 of the CRAs requirement that 97% of claims are paid accurately upon initial submission for the month of December 2012.

   (See Section VI.C.1. of this report)

3. Verification by TDCI of the claims payment accuracy report submitted by AGP for December 2012 indicated the following deficiencies:

   - AGP identified an error for one nursing facility claim where the monthly patient liability was incorrectly applied resulting in an incorrect payment

amount. The attempt by AGP to correct the error was unsuccessful since AGP did not properly consider the application of the monthly patient liability for other nursing facility claims for the patient in the same month of service.

- For five nursing facility claims in which only a partial month was billed by the provider, AGP incorrectly calculated the patient liability on a pro rata basis utilizing the number of inpatient days divided by total calendar days in the month. TennCare Bureau directives require, in most instances, the entire patient liability be applied up to the allowed amount on the first claim submitted for the month.

- AGP incorrectly included adjusted claims in its claims payment accuracy testing sample. Per Section 2.22.6 of the CRA, adjusted claims should not be included since the claims payment accuracy percentage is only measured on claims processed or paid accurately upon initial submission.

- The NEMT subcontractor does not retain the results of each attribute tested for audit purposes as required by Section 2.22.6.5.1 of the CRA.

- The NEMT subcontractor does not confirm that the payment amount agrees with contracted rate in the provider agreement per Section 2.22.6.4.5 of the CRA.

(See Section VI.C.4. of this report)

4. For one paid claim selected from focused claims testing, the final adjudication by AGP was not submitted to TennCare as encounter data.

(See Section VI.E. of this report)

5. AGP reported the following errors in their focused adjudication accuracy claims testing results for calendar year 2012:

- Six medical claims were incorrectly denied with the explanation that the claim was "submitted after plans limit". The claims were submitted timely. AGP indicated that the incorrect denials were due to manual error.

- Four medical claims were incorrectly denied with the explanation that the claim was “submitted after plans limit". The claims were submitted timely. AGP indicated that the incorrect denials were the result of a system error that has been corrected.

- One CHOICES claim was incorrectly denied with the explanation "The number of services provided exceeds the number approved in the Utilization Management". The number of services did not exceed the approved authorization.

- Eleven out of twelve service lines were incorrectly denied on one claim with the explanation “definite duplicate”. AGP determined that all eleven service lines on this claim should have paid since the first submission was inappropriately processed by AGP.

- One medical claim was incorrectly denied with the explanation "billing error". The claim should have denied with the explanation “no prior authorization”.

- One medical claim was incorrectly denied with the explanation "billing error". AGP determined that no billing error existed on the claim submitted by the provider. The claim should have processed for payment.

- One medical claim was incorrectly denied with the explanation that other insurance was the primary carrier. AGP determined that TennCare was the primary carrier. The claim should have processed for payment.

- One medical claim incorrectly denied with the explanation that the member was not TennCare eligible on all dates of service on the claim. AGP determined that the member was eligible on some of the dates of service on the claim. The claim should have paid for the dates the member was eligible.

- One CHOICES claim was incorrectly denied with the explanation "exceeds maximum number of units". AGP indicated that the claim should have denied with the reason "benefit limit reached" since the provider submitted a claim where the service dates billed exceeded a calendar month. The TennCare Bureau policies require providers not to submit claims in excess of one calendar month. TDCI disagrees that the explanation “benefit limit reached” effectively communicates the reason the claim was denied. A more appropriate denial reason would have explained that the services dates billed exceeded a calendar month.

- One CHOICES claim was incorrectly denied with the explanation “no authorization on file”. An authorization for the claim was on file and the claim should have processed for payment.

- One claim was incorrectly denied with the explanation "invoice required". AGP determined that the claim should have denied with the explanation of that no prior authorization was obtained.

- One claim was incorrectly denied with the explanation "modifier pricing applied". AGP indicated that the claim should have denied with the explanation of either duplicate claim or no authorization.

- One claim was incorrectly denied with the explanation "incorrect discharge status". AGP indicated that the claim should have denied with the explanation that no prior authorization was obtained.

- One claim was incorrectly denied with the explanation "resubmit with units/visits". AGP determined that the dates of services were incorrectly entered by AGP resulting in the inappropriate denial.

- One claim was incorrectly paid to the wrong provider. AGP adjusted the claim to pay to the correct provider.

- AGP indicated that for 13 claims selected for testing the information reported on the medical claim was incorrectly entered into the claims processing system. For 7 of the 13 claims, the claim was incorrectly rejected and returned to the provider. For 6 of the 13 claims, the keying error did not affect final denial or payment of the claims.

  (See Section VI.F.1. of this report)

6. The following additional claims adjudication issues were noted by TDCI during the review of AGP's monthly focused claims testing results:

   - A claim was incorrectly submitted with a status of "adjusted" in AGP's prompt pay data file submission. The claim should have been reported with a status of "paid". The proper reporting of a claim's status is significant because "adjusted" status claims are not included in the calculation of prompt pay compliance percentages.

   - Three claims were denied with only the explanation "Billing Error" communicated to the provider. The denial explanation "Billing Error" is vague and does not effectively communicate to the provider the reason the claim was denied.

- A claim with two service lines was processed by AGP: one service line with a "paid" status paid $0 with the explanation "included in per diem", and one service line denied with the explanation "billing error". Since no dollars were paid on the claim, the explanation "included in per diem" is invalid. Also as previously discussed above, the explanation "Billing Error" does not effectively communicate to the provider the reason the claim was denied.

- AGP indicated 15 claims were incorrectly rejected by AGP's data entry vendor because the vendor could not validate the National Provider Identification number (NPI) of the provider. The NPI submitted by the provider was valid. The claims were later reopened and processed but delays of this nature should be prevented.

  (See Section VI.F.3. of this report)

7. Significant claims adjudication issues related to CHOICES claims submitted via the separate Electronic Visit Verification system (EVV) were noted by TDCI during the review of AGP's monthly claims focused testing. TDCI noted the incorrect denial by AGP of CHOICES claims for services not prior authorized and for billed services exceeded the authorized units. Many of the incorrect denials were the result of AGP's processes establishing prior authorizations and the manner in which the authorizations were utilized by the providers in the EVV. Since authorizations lacked specificity in relation to day of the week, providers were able to submit claims via the EVV from available authorized units even though these units were related to a different authorization in AGP's claims system. In December 2012, AGP indicated they initiated stricter member preferred scheduling to correct this issue. Additionally, TDCI noted that procedures in the EVV incorrectly transmitted to AGP's claims processing system the National Provider Identification (NPI) numbers for three providers which utilize multiple NPI numbers. AGP denied claims for no prior authorization in these instances since the NPI submitted on the claim must match the NPI for which the authorization was granted.

   (See Section VI.F.4. of this report.)

8. AGP found when performing focused claims testing in calendar year 2012 that three claims were incorrectly paid because the payment amount did not agree with the contracted rate in the provider agreement.

   (See Section VI.G. of this report.)

9. AGP subcontractors, Block Vision and Tennessee Carriers did not comply with section 2.22.10.4 of the CRA and 42 CFR 455.18 and 455.19 which require the specific attestation language regarding false claims be included on each remittance advice sent to providers.

(See Section VI.G. of this report.)

10. Review of mailroom and claims inventory controls for an AGP subcontractor, Tennessee Carriers, noted deficiencies in tracking and reconciliation of non-emergency transportation claims received from providers in the mailroom.

    (See Section VI.L. of this report.)

11. The following deficiencies were noted in the review of reimbursement changes as the result of the State of Tennessee budget requirements effective July 1, 2011.

    For emergency department professional fees to be capped at $50 for non-emergency claims, the following issues were reported to AGP in June 2012:

    - Four claims incorrectly paid over $50 where the first and second diagnosis reported is non-emergent. The claims system incorrectly considered the third diagnosis code in the determination of emergent versus non-emergent.

    - One non-emergent claim incorrectly paid over $50. This non-emergent claim was paid before the system was configured for the Budget requirements.

    - One non-emergent claim underpaid due to a manual error by the adjudicator.

    During the examination fieldwork, TDCI noted AGP had not adjusted three of the four claims previously identified that paid more than $50 where the claims system incorrectly considered the third diagnosis code in the determination of emergent versus non-emergent.

    (See Section VI.M.1. of this report.)

C. Compliance Deficiencies

1. For one of the four complaints selected for testing by TDCI from provider complaints received via the TennCare Bureau, AGP did not respond to the provider within 60 days. Tenn. Code Ann. § 56-32-126(b)(2)(A) requires AGP to inform the provider if AGP determines it needs longer than 30 days to completely respond to the provider complaint and that a decision shall be made within 60 days of receipt.

   (See Section VII.A.1. of this report.)

2. For the test month of December 2012, the following deficiencies were noted in review of the provider appeal complaint log:

- Four of the ten complaints selected for testing were not resolved within 30 days and AGP failed to inform the provider that a decision would be made within 60 days of receipt. Tenn. Code Ann. § 56-32-126(b)(2)(A) requires AGP to inform the provider if AGP determines it needs longer than 30 days to completely respond to the provider complaint and that a decision shall be made within 60 days of receipt.

- Three of the ten provider complaints selected for testing were not resolved within 60 days and no written agreement with the provider was executed to allow for additional time to resolve the complaint. Tenn. Code Ann. § 56-32-126(b)(2)(A) requires AGP to reach an agreement in writing for additional time to resolve the complaint with the provider if resolution of the provider complaint will exceed 60 days.

  (See Section VII.A.2. of this report.)

3. A review of 10 complaints received by TDCI against AGP noted the following deficiencies related to claims adjudication accuracy:

   - One claim was incorrectly denied by AGP for exceeding timely filing limit of 120 days; however, AGP received the claim 115 days after date of service.

   - One emergency room claim processed by AGP incorrectly paid $50 as non-emergent even though the diagnosis was an emergency as defined by AGP. A subsequent reprocessing project by AGP incorrectly reversed the payment on this claim to zero dollars. The provider resubmitted the claim and AGP denied the claim for exceeding timely filing limits. At this point the provider complained to TDCI and AGP reprocessed and paid the claim at the contracted emergency diagnosis rate.

     (See Section VII.B. of this report.)

4. A review of 5 independent review decisions between providers and AGP found that one claim incorrectly denied EPSDT service lines for other insurance. EPSDT services should not be denied on first processing for other insurance.

   (See Section VII.C. of this report.)

5. A review of ten provider agreements executed by AGP and subcontractors noted the following deficiencies:

   - The executed agreement between Block Vision and a national vision service provider did not contain all of the language requirements of Section 2.12.7 of the CRA. Additionally, the executed agreement was never submitted for prior approval to TDCI per Tenn. Code Ann. § 56-32-103(c)(1). AGP also found

that another national vision service provider contract did not contain all of the language requirements of Section 2.12.7 of the CRA and had not been submitted to TDCI for prior approval.

- The template provider agreement between TNC and an NEMT provider was submitted and approved by TDCI on October 7, 2008. However, TNC did not utilize the prior approved template agreement but instead executed an earlier draft version of the provider agreement which did not meet all of the language requirements of Section 2.12.7 of the CRA.

  (See Section VII.E. of this report.)

- Information systems policies and procedures for AGP's subcontractor, Tennessee Carriers, did not include specific requirements for personnel to contact the TennCare privacy officer immediately upon becoming aware of any unauthorized use or disclosure of enrollee protected health information not otherwise permitted or required by HIPAA per section 2.27.8 or the CRA.

  (See Section VII.L. of this report.)

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 TDCI. 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.

As of December 31, 2012, AGP reported $212,184,230 in admitted assets, $106,104,385 in liabilities and $106,079,845 in capital and surplus on the 2012 Annual Statement submitted March 1, 2013. AGP reported total net income of $25,844,500 on the statement of revenue and expenses. The 2012 Annual Statement and other financial reports submitted by AGP can be found at http://www.tn.gov/commerce/tenncare/mcoreports.shtml.

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 for its provision of services to TennCare enrollees are to be included in the calculation of net worth and deposit requirements, regardless of the reporting requirements for the NAIC statements.

Section 2.21.6.1 of the CRA requires AGP to establish and maintain the minimum net worth requirements required by TDCI, including but not limited to Tenn. Code Ann. § 56-32-112.

To determine the minimum net worth requirement as of December 31, 2012, TDCI utilized the greater of (1) the total annual premium revenue earned as reported on the NAIC Annual Statement for the period ending December 31, 2012, or (2) to the total payments made to AGP by the TennCare Bureau for 2012 plus premium revenue from non-TennCare operations.

(1) For the period ending December 31, 2012, AGP reported TennCare premiums of $863,517,958 and Medicare premiums of $41,362,158 for a total of $904,880,116 annual premium revenue.

(2) AGP received $862,141,326 in monthly capitation payments for 2012 from the TennCare Bureau and premium revenue from non-TennCare operations of $41,362,158 for a total of $903,503,484.

Utilizing $904,880,116 as the premium revenue base, AGP's minimum net worth requirement as of December 31, 2012 is $17,323,202 [($904,880,116-$150,000,000) x 1.5% + ($150,000,000 x 4%)]. AGP's reported net worth of $106,079,845 as of December 31, 2012 is $88,756,643 in excess of statutory minimum net worth requirements.

2. Restricted Deposit

Tenn. Code Ann. § 56-32-112(b) requires HMOs to establish a restricted deposit and defines the calculation of the deposit based upon annual premium revenue. AGP's required restricted deposit for the year ending December 31, 2012 is

$5,750,000 based upon the formula defined in Tenn. Code Ann. § 56-32-112(b). However, Section 2.21.6.4 of CRA requires MCOs to have on deposit an amount equal to the calculated minimum net worth requirement per Section 2.21.6.1 of the CRA. Utilizing only the TennCare premiums for the calendar year 2012 of $863,517,958, AGP's required restricted deposit per Section 2.21.6.4 of CRA is $16,702,769. As of the March 1, 2013 due date for the NAIC Annual Statement for the year ending December 31, 2012, AGP had on file with TDCI safekeeping receipts totaling $17,366,000 to satisfy restricted deposit requirements.

3. Claims Payable

AGP reported $72,842,721 claims unpaid as of December 31, 2012. Of the total claims unpaid reported, $68,909,152 represented the claims unpaid for TennCare operations. The reported amount was certified by a statement of actuarial opinion. Analysis by TDCI of the triangle lag payment reports through June 30, 2013, for dates of services before January 1, 2013, and review of subsequent NAIC financial filings determined that the reported claims payable for TennCare operations was adequate.

B. TennCare Operating Statement

Sections 2.30.16.3.3 and 2.30.16.3.4 of the 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. For the year ended December 31, 2012, AGP's TennCare Operating Statement reported Total Revenues of $866,567,837, Medical Expenses of $706,482,208, Administrative Expenses of $123,742,960, Income Tax Expense of $12,281,677 and Net Income of $24,060,992.

No reportable deficiencies were noted in the preparation of the TennCare Operating Statement.

C. Medical Loss Ratio Report

Section 2.30.16.2.1 of the CRA requires:

> The CONTRACTOR shall submit a *Medical Loss Ratio Report* monthly with cumulative year to date calculation. 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 August 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 shall

> reconcile to NAIC filings including the supplemental TennCare income statement. The CONTRACTOR shall also reconcile the amount paid reported on the supporting claims lag tables to the amount paid for the corresponding period as reported on the CONTRACTOR's encounter file submission as specified in Sections 2.30.18.3 and 2.23.4.

The medical loss ratio (MLR) reports as submitted on January 21, 2013 for the period July 1, 2012, through December 31, 2012, originally reported an MLR of 87.66%. TDCI reviewed the MLR reports for the same period July 1, 2012, though December 31, 2012, submitted on July 21, 2013, which reported an adjusted MLR of 83.91%. The reason for the noted decrease in the MLR percentage was due to adjustments of incurred but not reported (IBNR) estimates. Over time the IBNR estimates can be reduced with the submission and payment of actual claims. The procedures and supporting documents to prepare the MLR report were reviewed. No discrepancies were noted during the review of documentation supporting the amounts reported on the MLR report.

D. Administrative Expenses and Management Agreement

For the year ended December 31, 2012, AGP reported total Administrative Expenses of $127,968,838 which included direct expenses incurred by AGP and administrative and support services fees paid pursuant to the management agreement between AGP and AMERIGROUP Corporation. Administrative Expenses represented 14.1% of total premium revenue. The management agreement requires AMERIGROUP Corporation to perform certain 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. The fee is calculated utilizing all of the following components:

- A per member per month fee,
- Percentage of adjusted premium revenue,
- Percentage of premium revenue if AGP renders pharmacy managed care services, and
- Ten percent of the per member per month fee and ten percent of the premium calculations above.

For the year ended December 31, 2012, management fees of $43,895,614 were charged to AGP by AMERIGROUP Corporation. The management fee represented 4.90% of total premium revenue.

No deficiencies were noted during the review of the management agreement.

E. Schedule of Examination Adjustments to Capital and Surplus

No adjustments are recommended to Capital and Surplus for the period ending December 31, 2012, as a result of the examination of AGP's TennCare operations.

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 2.22.4 of the 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.

TDCI currently determines compliance with Tenn. Code Ann. § 56-32-126(b)(1) by testing monthly data file submissions from each of the TennCare MCOs. Each month is tested in its entirety for compliance with the prompt pay requirement of the statute. If a TennCare MCO fails to meet the prompt pay standards for any subsequent month after the month in which non-compliance was communicated by TDCI, the MCO will be penalized as allowed by the statute in an amount not to

exceed ten thousand dollars ($10,000). The TennCare MCO is required to maintain compliance with prompt pay standards for twelve months after the month of failure to avoid the penalty.

Prompt Pay Results for All Claims Processed

The following table represents the results of prompt pay testing combined for all TennCare claims processed by AGP, the vision subcontractor, and the NEMT subcontractor.

AGP Middle All TennCare Operations	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2012	99%	100.0%	**Yes**
February 2012	99%	100.0%	**Yes**
March 2012	97%	99.9%	**Yes**
April 2012	98%	99.8%	**Yes**
May 2012	100%	99.9%	**Yes**
June 2012	99%	99.9%	**Yes**
July 2012	99%	100.0%	**Yes**
August 2012	99%	99.9%	**Yes**
September 2012	99%	99.9%	**Yes**
October 2012	99%	100.0%	**Yes**
November 2012	99%	99.9%	**Yes**
December 2012	99%	100.0%	**Yes**

When combining the results for all claims processed, AGP was in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for all months in 2012.

Prompt Pay Results for Vision Claims

Separate testing of the claims processed by the vision subcontractor, Block Vision, found that Block Vision processed claims timely for all months in 2012.

Prompt Pay Results for NEMT Claims

Sections A.15.3 and A.15.4, of ATTACHMENT XI to the CRA require AGP to comply with the following prompt pay claims processing requirements for NEMT claims:

- The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for NEMT services delivered to a member are processed within thirty (30) calendar days of the receipt of such claims.

- The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all NEMT provider claims for covered NEMT services delivered to a member.

The following instance of noncompliance was determined for NEMT claims during calendar year 2012:

Month	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
June 2012	96%	99.2%	**NO**

Management Comments
AGP concurs. The 60 day non-compliance from June 2012 was caused by a TNC vendor failing to acknowledge the correction of approximately 175 claims that sat dormant for approximately 12 months waiting on vendor acknowledgement of the corrected authorization. To correct the situation that resulted in the deficiency, TNC began suspending claims that were returned to vendors for additional approval. These claims are flagged as “non-clean” claims and subsequent receipt dates are used for reporting the claims when the status changes to “clean”. This process began in July 2012. Additionally in September 2012, TNC began to process and pay claims on a weekly basis.

Prompt Pay Results for CHOICES Claims

Pursuant to Section 2.22.4 of the CRA, AGP is required to comply with the following prompt pay claims processing requirements for nursing facility claims and for certain home and community based services (HCBS) claims submitted electronically in a HIPAA-compliant format:

- Ninety percent (90%) of clean claims for nursing facility services and HCBS excluding personal emergency response systems (PERS), assistive technology, minor home modifications, and pest control shall be processed and paid within fourteen (14) calendar days of receipt.

- Ninety-nine point five percent (99.5%) of clean claims for nursing facility and HCBS other than PERS, assistive technology, minor home modifications, and pest control shall be processed and paid within twenty-one (21) calendar days of receipt.

Prompt pay testing determined that CHOICES claims were processed in compliance with Section 2.22.4 of the CRA for all months during the 2012 calendar year.

The complete results of TDCI's prompt pay compliance testing can be found at http://www.tn.gov/tncoversight/promptpaybpm.shtml.

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 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, and

- Review of internal controls related to claims processing.

As noted below, TDCI discovered deficiencies related to AGP's procedures for preparing the Claims Payment Accuracy Reports. A discussion of the sample selection methodology can be found in Section VI.D. of this report.

C. Claims Payment Accuracy

1. Claims Payment Accuracy Reported by AGP

Section 2.22.6 of the CRA requires that 97% of claims are processed or paid accurately upon initial submission. On a monthly basis, UPRV submits claims payment accuracy percentage reports to TennCare based upon audits conducted by UPRV. A minimum sample of one hundred and sixty (160) claims randomly selected from the entire population of electronic and paper claims processed or paid upon initial submission for the month tested is required. Additionally, each monthly sample of one hundred and sixty (160) claims shall contain a minimum of thirty (30) claims associated with nursing facility services provided to CHOICES members and thirty (30) claims associated with HCBS provided to CHOICES members. The testing attributes to be utilized by UPRV are defined in the CRAs between UPRV and the TennCare Bureau. Additionally, subcontractors responsible for processing claims shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor. The following table represents claims payment accuracy percentages reported by AGP for the examination period January 1, 2012 through December 31, 2012.

All Claims	Medical	LTC-NF	HCBS	Total
January 2012	100%	99%	98%	99%
February 2012	100%	99%	99%	99%
March 2012	99%	99%	99%	99%
April 2012	99%	98%	98%	99%
May 2012	100%	99%	99%	99%
June 2012	99%	99%	99%	99%
July 2012	99%	99%	99%	99%
August 2012	99%	98%	99%	99%
September 2012	100%	99%	99%	99%
October 2012	99%	99%	99%	99%
November 2012	100%	99%	99%	99%
December 2012	100%	**71%**	100%	**93%**

AGP failed to achieve claims payment accuracy requirements of 97% per Section 2.22.6 of the CRA for long term care nursing facility and all claims processed for the month of December 2012.

Management Comments

AGP concurs. Claims impacted in the audit sample were a result of adjusted claims due to rate updates. During adjudication of the claims via batch processing, patient liability was not applied appropriately. AGP determined that it would not be able to adjudicate LTC-NF claims via macro processing. In addition, the audit sampling process was updated to include "upon initial receipt" claims only. Claims payment accuracy has been achieved since that time.

2. Claims Payment Accuracy Reported by the NEMT Subcontractor

   ATTACHMENT XI Section A.15.5 of the CRA requires AGP to pay 97% of NEMT claims accurately upon initial submission. Additionally, ATTACHMENT XI Section A.15.6 of the CRA requires an audit of NEMT claims that complies with the requirements in the CRA regarding a claims payment accuracy audit. The NEMT subcontractor, TN Carriers, performed and reported compliance with monthly claims payment accuracy requirements for all months in calendar year 2012.

3. Procedures to Review the Claims Payment Accuracy Reports

   The review of the claims payment accuracy reports included an interview with responsible staff of AGP and the NEMT subcontractor 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 and the NEMT subcontractor agreed to requirements of Sections 2.22.6 and ATTCHMENT XI Section A.15.5 and A.15.6 of the CRA. These interviews were followed by a review of the supporting documentation used to prepare the December 2012 claims payment accuracy reports. From AGP's December 2012 claims payment accuracy report, TDCI selected for verification five claims reported as errors and ten claims reported as accurately processed. From the NEMT subcontractor's December 2012 claims payment accuracy report, TDCI selected for verification five claims reported as accurately processed. Since no claims were reported as errors on the December 2012 NEMT claims payment accuracy report, no error claims were selected for verification. 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 2.22.6.4 of the CRA.

4. Results of TDCI's Review of the Claims Payment Accuracy Reporting

   For the claims selected for verification from AGP's and the subcontractor's December 2012 claims payment accuracy reports, the following deficiencies were noted:

   - AGP determined it incorrectly applied the monthly patient liability which resulted in an incorrect payment of one nursing facility claim. The attempt by AGP to correct the error was unsuccessful since AGP did not properly consider the application of the monthly patient liability for other nursing

facility claims for the patient in the same month of service.

- For five nursing facility claims in which only a partial month was billed by the provider, AGP incorrectly calculated the patient liability on a pro rata basis utilizing the number of inpatient days divided by total calendar days in the month. TennCare Bureau directives require in most instances that the entire patient liability be applied up to the allowed amount on the first claim submitted for the month.

- AGP incorrectly included adjusted claims when selecting claims for claims payment accuracy testing. Per section 2.22.6 of the CRA, adjusted claims should not be included since the claims payment accuracy percentage is only measured on claims processed or paid accurately upon initial submission.

- The NEMT subcontractor does not retain the results of each attribute for audit purposes as required by the section 2.22.6.5.1 of the CRA.

- The NEMT subcontractor does not confirm that the allowed payment amount agrees with contracted rate in the provider agreement per section 2.22.6.4.5 of the CRA.

Management Comments

As to the first and second bulleted comments above, AGP concurs. Processing instructions for patient liability were updated and training provided to claims staff. AGP determined this was a manual process and claims cannot adjudicate through batch processing. A project was implemented on 8/23/13 to enhance the payment accuracy for processing LTC-NF claims for patient liability.

As to the third bulleted comment above, AGP concurs. AGP's original interpretation of requirements included total population of processed claims for claims accuracy audit testing. Queries for audits were built to include the total population of all claims processed to include adjusted claims. Issues with adjusted claims that lead to lower quality results caused a review of CRA § 2.22.6.3 and the applicable identified language "claims upon initial submission". AGP removed adjusted claims from the population of claims it audits for accuracy results. AGP also built a separate audit specifically for adjusted claims.

As to the fourth and fifth bulleted comments above, AGP concurs. TNC has initiated an audit process whereby claims attribute testing results are recorded and maintained utilizing the “TNC Claims Audit Attribute Testing Spreadsheet”. Results are gathered and maintained for all claims tested, regardless of whether the claim passes or fails.

D. Claims Selected For Testing

As previously mentioned, medical claims are processed by the parent of AGP, vision claims are processed by the subcontractor Block Vision, Inc., and NEMT claims are processed by the subcontractor Tennessee Carriers, Inc.

Effective January 1, 2012, the CRA included additional monthly focused claims testing requirements that require AGP to self-test the accuracy of claims processing based on claims selected by TDCI. For examination purposes, TDCI utilized the results of the focused claims testing to evaluate the accuracy of the claims processing system.

For monthly focused claims testing by AGP during calendar year 2012, TDCI judgmentally selected 25 claims from the data files submitted by AGP for prompt pay testing purposes. The focused areas for testing during calendar year 2012 included the following:

- Paid and denied medical inpatient claims
- Paid and denied medical outpatient claims
- Adjusted claims
- Claims with processing lags over 60 days
- Paid and denied CHOICES nursing facility claims
- Paid and denied CHOICES HCBS claims
- Claims processed by subcontractors
- Claims denied for exceeding timely filing limits

Each month, TDCI selected the claims sample and specified the attributes AGP was to test to determine if the claims were accurately processed. For calendar year 2012, AGP reported 38 out of 300 claims selected for testing contained at least one attribute error. During field test work, TDCI:

- Reviewed all claims reported by AGP as errors,
- Reviewed a judgmentally selected sample of 36 claims for which no errors were reported by AGP, and
- Followed up on claims processing issues identified by TDCI from its review of AGP's monthly focused claims testing results.

The results of TDCI's examination of AGP's focused claims testing are set forth below.

E. Comparison of Actual Claim with System Claim Data

The purpose of this test was to ensure that the information submitted on the claim was entered correctly in AGP's or subcontractor's claims processing system. The CRA requires minimum data elements to be recorded from medical claims and submitted to TennCare as encounter data. The data elements recorded on the claims were compared to the data elements entered into AGP's or subcontractor's claims processing system. The following discrepancy was noted on one claim in the accuracy of encounter data reporting:

1. During monthly focused claims testing, AGP determined a member was eligible for only part of the inpatient length of stay. An internal process by AGP split the claim based upon eligible days in order to process the claim. The payment of this split claim could not be found in the encounter data submitted to the TennCare Bureau. The accuracy of the encounter data submissions is required by the CRA in order for the TennCare Bureau to monitor financial reporting and utilization analysis of the program.

   Management Comments

   AGP does not concur. The applicable claim was split and submitted at separate times. A second claim version was created for service dates 6/1/2012 – 6/10/2012 which was zero paid and was included in the encounter file submitted on July 9, 2013. The third version of the claim was created for service dates 6/11/2012 – 6/30/2012 and contained the paid amount of $2,313.60. This claim was included in the encounter submitted on October 23, 2012.

   TDCI Rebuttal

   As of the first date of fieldwork, the complete submission of the claim as encounter data had not occurred.

2. TDCI compared the actual claim data with claim system data for the 36 claims selected from the monthly focused claims testing results in which no error was reported by AGP. TDCI verified that the actual claim data agreed to claim system data for the 36 claims tested.

F. Adjudication Accuracy Testing

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

3. AGP reported the following errors in their monthly focused claims testing results for calendar year 2012 related to adjudication accuracy:

- Six medical claims were incorrectly denied with the explanation that the claim was "submitted after plans limit". The claims were submitted timely. AGP indicated that the incorrect denials were due to manual error.

- Four medical claims were incorrectly denied with the explanation that the claim was “submitted after plans limit". The claims were submitted timely. AGP indicated that the incorrect denials were the result of a system error that has been corrected.

- One CHOICES claim incorrectly denied with the explanation "The number of services provided exceeds the number approved in the Utilization Management". The number of services did not exceed the approved authorization.

- Eleven out of twelve service lines were incorrectly denied on one claim with the explanation “definite duplicate”. AGP determined that all eleven service lines on this claim should have paid since the first submission was inappropriately processed by AGP.

- One medical claim was incorrectly denied with the explanation "billing error". The claim should have been denied with the explanation that the required prior authorization was not obtained.

- One medical claim was incorrectly denied with the explanation "billing error". AGP determined that no billing error existed on the claim submitted by the provider. The claim should have processed for payment.

- One medical claim was incorrectly denied with the explanation that other insurance was the primary carrier. AGP determined that TennCare was the primary carrier. The claim should have processed for payment.

- One medical claim incorrectly denied with the explanation that the member was not TennCare eligible on all dates of service on the claim. AGP determined that the member was eligible on some of the dates of service on the claim. The claim should have paid for the dates the member was eligible.

- One CHOICES claim was incorrectly denied with the explanation "exceeds maximum number of units". AGP indicated that the claim should have been denied with the reason "benefit limit reached" since the provider submitted a claim via the separate electronic visit verification system (EVV) where the service dates billed exceeded a calendar month. The TennCare Bureau

policies require providers not to submit claims in excess of one calendar month. TDCI disagrees that the explanation “benefit limit reached” effectively communicates to the provider the reason the claim was denied. A more appropriate denial reason would have explained that the services dates billed exceeded a calendar month.

- One CHOICES claim was incorrectly denied with the explanation “no authorization on file”. An authorization for the claim was on file and the claim should have been paid.

- One claim was incorrectly denied with the explanation "invoice required". AGP determined that the claim should have been denied with the explanation that no prior authorization was obtained.

- One claim was incorrectly denied with the explanation "modifier pricing applied". AGP indicated that the claim should have been denied with the explanation that either the claim was a duplicate or no prior authorization was obtained.

- One claim was incorrectly denied with the explanation "incorrect discharge status". AGP indicated that the claim should have been denied with the explanation that no prior authorization was obtained.

- One claim was incorrectly denied with the explanation "resubmit with units/visits". AGP determined that the dates of services were incorrectly entered into the claims processing system by AGP, resulting in the inappropriate denial.

- One claim was incorrectly paid to the wrong provider. AGP adjusted the claim to pay to the correct provider.

- AGP indicated the information reported on the medical claim was incorrectly entered into the claims processing system for 13 claims selected for testing. For 7 of the 13 claims, the claim was incorrectly rejected and returned to the provider. For 6 of the 13 claims, the keying error did not affect the final denial or payment of the claims.

4. TDCI tested the adjudication accuracy of 36 claims from the monthly focused claims testing results in which no error was reported by AGP. No adjudication errors were noted.

5. The following additional claims adjudication issues were noted by TDCI during the review of the monthly focused claims testing results:

   - A claim was incorrectly submitted with a status of “adjusted” in AGP’s prompt pay data file submission. The claim should have been reported with a status of “paid”. The proper reporting of a claim’s status is significant because “adjusted” status claims are not included in the calculation of prompt pay compliance percentages.

   - Three claims were denied with only the explanation "Billing Error communicated to the provider. The denial explanation “Billing Error” is vague and does not communicate to the provider all known reasons for denial as required Tenn. Code Ann. § 56-32-126(b)(1)(B).

   - A claim with two service lines was processed by AGP: one service line processed with a “paid” status paid $0 with the explanation “included in per diem”, and one service line was denied with the explanation “billing error”. Since no dollars were paid on the claim, the explanation “included in per diem” is invalid. Also as previously discussed above, the denial reason “Billing Error” does not effectively communicate to the provider the reason the claim was denied.

     AGP indicated 15 claims were incorrectly rejected by AGP’s data entry vendor because the vendor could not validate the National Provider Identification number (NPI) of the provider. The NPI submitted by the provider was valid. The claims were later reopened and processed, but these errors resulted in significant processing delays.

     <u>Management Comments</u>
     As to the first bulleted comment above, AGP concurs. Only certain procedure lines of the claim were adjusted while the other lines were paid. AGP now does not report any line of a first submission claim as adjusted.

     As to the second and third bulleted comments above, AGP concurs. Effective March 1, 2014, AGP will only apply the “Billing Error” denial code as a last resort if no other denial code clearly identifies the reason for denial. When using the “Billing Error" denial code, the claims analyst will also add specific explanation of payment (EOP) notes identifying the detailed reason for the billing error denial.

6. Significant claims adjudication issues related to CHOICES claims submitted via the separate Electronic Visit Verification system (EVV) were noted by TDCI during the review of AGP's monthly claims focused testing. TDCI noted the incorrect denial by AGP of CHOICES claims for services not prior authorized and for billed services exceeded the authorized units. Many of the incorrect denials were the result of AGP's processes establishing prior authorizations and the manner in which the authorizations were utilized by the providers in the EVV. Since authorizations lacked specificity in relation to day of the week, providers were able to submit claims via the EVV from available authorized units even though these units were related to a different authorization in AGP's claims system. In December 2012, AGP indicated they initiated stricter member preferred scheduling to correct this issue. Additionally, TDCI noted that procedures in the EVV incorrectly transmitted to AGP's claims processing system the National Provider Identification (NPI) numbers for three providers which utilize multiple NPI numbers. AGP denied claims for no prior authorization in these instances since the NPI submitted on the claim must match the NPI for which the authorization was granted.

   Management Comments
   AGP concurs. As part of its improvement efforts, AGP has made several key claims processing changes in order to address and mitigate the potential for incorrect denials for claims submitted through the EVV. Specifically, AGP has put in place additional controls to ensure that the authorization reference number, associated with the specific schedule for which a claim has been submitted, is always the authorization used in processing. Also, prior to denying EVV claims for authorization issues, an additional level of review has been implemented to ensure that the denial is appropriate. As a result of its improvement efforts, AGP has seen a decrease in denials associated with authorization issues for those claims submitted through the EVV.

G. 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 reported the following errors in their focused claims testing results for calendar year 2012 related to price accuracy testing; 3 claims were incorrectly paid because the allowed payment amount did not agree with the contracted rate in the provider agreement.

- TDCI tested the pricing accuracy of 36 claims from the monthly focused claims testing results in which no error was reported by AGP. No pricing accuracy errors were noted.

H. Copayment Testing

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

TDCI requested from AGP a listing of the 100 enrollees with the highest accumulated copayments for the period January 1, 2012 through December 31, 2012. From the listing, five enrollees were judgmentally selected and all of the claims processed for those enrollees in calendar year 2012 were analyzed to determine if AGP had correctly applied copayment requirements of the CRA based upon the enrollee's eligibility status. No discrepancies were noted during copayment testing.

I. Remittance Advice Testing

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

AGP subcontractors, Block Vision and Tennessee Carriers did not comply with section 2.22.10.4 of the CRA and 42 CFR 455.18 and 455.19 which requires the following language be included on each remittance advice sent to providers:

> "I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws."

Management Comments
AGP concurs. The above language has been added to the remittance advices for both Block Vision and TNC.

J. Analysis of Cancelled Checks and Electronic Funds Transfer (EFT)

The purpose of analyzing cancelled checks and/or EFT was 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.

TDCI requested AGP to provide ten cancelled checks or EFT documentation related to claims previously tested by TDCI. AGP provided the cancelled checks or the proof of EFT. The documents provided agreed with the amounts paid per the

remittance advices and no pattern of significant lag times between the issue date and the cleared date was noted.

K. 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 June 30, 2013, were reviewed for claims which were unprocessed and exceeded 60 days old from receipt date. The pended and unpaid data file of claims unprocessed by AGP, as well as subcontractors, indicate a total of 230 claims exceeding 60 days in process. No material liability exists for claims over 60 days.

L. 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.

TDCI did not perform a site visit of the mailroom operations of AGP and its subcontractors, Block Vision and TNC, during this examination; however, TDCI performed the following procedures to review mailroom and claims inventory controls:

- Responses to internal control questionnaires regarding mailroom operations were reviewed,
- Staff of each mailroom were interviewed,
- Current mailroom processes were compared to the site visit results from the previous examination for AGP only, and
- Flowcharts documenting mailroom processes were reviewed.

AGP and Block Vision Mailroom and Claims Inventory Controls

No reportable deficiencies were noted by TDCI during the review of the mailroom and claim inventory controls for AGP and Block Vision.

TNC Mailroom and Claims Inventory Controls

TNC does not maintain an inventory log of all claims received in the mailroom. Without a claims inventory log, TNC is unable to perform a reconciliation to ensure that all claims received are entered into the system or rejected and sent back to the provider for correction. TNC should develop and maintain an inventory log for all claims received in the mailroom which should include the date a claim is rejected

and returned to the provider. TNC should periodically reconcile the inventory log to ensure all claims received in the mailroom have been processed by the claims system or rejected and returned to the provider.

Management Comments
AGP concurs. TNC has developed a mailroom and receiving procedure whereby an inventory log is kept for all claims received in the mailroom.

M. Budget Reimbursement Changes Effective July 1, 2011 and July 1, 2012

The Budgets for the State of Tennessee (Budgets) effective July 1, 2011 and July 1, 2012, required all TennCare managed care organizations to implement reimbursement changes to provider payments effective July 1, 2011. The Bureau of TennCare requested TDCI to review three of the reimbursement changes implemented by all TennCare managed care organizations.

1. Emergency Department Professional Fees

The Budgets required reimbursement for professional fees for non-emergency emergency department visits to be capped at $50. If the contracted rate between the provider and AGP is lower than $50 for the service billed, then AGP is to pay the contracted rate. AGP determines if a claim is considered emergent when either the first or second diagnosis on the claim is listed on AGP's predetermined emergency diagnosis code listing. The TennCare Bureau provided a data file of claims billed with procedure codes for emergency room professional fees for dates of service on or after July 1, 2011. TDCI selected 117 claims for testing from the data file. The selected claims included claims which paid less than $50, $50, and more than $50. The following deficiencies were noted:

- Four claims incorrectly paid over $50 when the first and second diagnoses reported were non-emergent. The claims system incorrectly considered the third diagnosis code in the determination of emergent versus non-emergent.

- One non-emergent claim incorrectly paid over $50. This non-emergent claim was paid before the system was configured for the Budget requirements.

- One non-emergent claim underpaid due to a manual error by the adjudicator.

AGP responded that reprocessing projects were under development to correct the payment of claims where the third diagnosis code was incorrectly considered and of non-emergent claims that were processed before the configuration for Budget requirements. An automated process is being developed to correct the

third diagnosis code issue.

During the examination fieldwork, TDCI noted AGP had not adjusted three of the four claims previously identified as being paid more than $50 because the claims system incorrectly considered the third diagnosis code in the determination of emergent versus non-emergent.

Management Comments
AGP concurs. Systemic configuration has been implemented. The residual claims have since been adjusted to pay correctly for the emergent services.

2. Professional Delivery Rates

The Budget effective July 1, 2011, required the reimbursement of professional fees to increase by 17% for normal deliveries and to pay for Caesarean deliveries at the same rate as normal deliveries for dates of service on and after July 1, 2011. TDCI selected seven providers receiving payments for professional delivery services. The rates for normal professional delivery services were tested to confirm that the 17% rate increase was applied to all claims with dates of service on and after July 1, 2011. Also, the rates for Caesarean professional delivery services were tested to confirm that the Caesarean professional delivery rates were the same as normal professional delivery rates for dates of service on and after July 1, 2011. No discrepancies were noted.

3. Facility Delivery Rates

The Budget effective July 1, 2011, required reimbursement for hospital fees to increase by 17% for normal deliveries and to pay for Caesarean deliveries at the same rate as normal deliveries for dates of service on and after July 1, 2011. The TennCare Bureau provided a data file of claims for hospital delivery reimbursements for dates of service before and after July 1, 2011. Through data analysis techniques for dates of service on or after July 1, 2011, TDCI identified normal delivery claims, that were not paid at the increased rate and Caesarean delivery claims that were paid at rates different than the normal delivery rates. TDCI selected a sample of claims these claims for testing. It was ultimately determined that these claims were paid correctly. However, AGP decided from researching these claims that an expanded review was necessary to determine if the Budget requirements had been properly applied.

In October 2012, AGP began a project to review 489 manually processed claims for vaginal and caesarean deliveries, with and without complications, for dates of services July 1, 2011 through October 12, 2012. The purpose of this project was to validate that claim payment amounts matched the respective hospital's configured reimbursement amount.

The results of AGP's review of these 489 claims are as follows:

- 444 claims were processed correctly,
- 44 claims were identified as overpayments and sent for recoupment, and
- 1 claim was identified as an underpayment and has been adjusted.

AGP completed this project in November 2012 and found that no additional claim payments or recoveries were necessary.

During the examination fieldwork, TDCI performed additional payment accuracy testing and found no discrepancies.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints Received by AGP

Provider complaints were tested to determine if AGP responded to all provider complaints in a timely manner. Tenn. Code Ann. § 56-32-126(b)(2)(A) states in part:

> 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 maintains two provider complaint logs. One log tracks provider complaints received via the TennCare Bureau, while a separate log tracks provider complaints received through AGP's claims processing department. TDCI reviewed four provider complaints from the 2012 TennCare Bureau provider complaint log and ten provider complaints from the December 2012 AGP claims processing department provider complaint log. The following deficiencies were noted.

1. Provider Complaints Received via the TennCare Bureau

For one of the four complaints selected for testing by TDCI, AGP did not respond to the provider within 60 days.

Management Comments
AGP concurs. AGP recognizes the noted failure and the following corrective actions have put in place to ensure that no further deficiencies are found specifically related to the failure to respond to provider complaints within 60 days: AGP Operations Desktop's were updated on 06/13/2013 to include reference to Tennessee Code 56-32-126(b)(2)(A), a template was created for provider acknowledgement and if warranted a phone call to the provider will also be made. The AGP BSD (Bureau Service Desk) share point site has been encapsulated so all documentation, including detailed research and correspondence, will be captured in one place. Cross training of the AGP Internal Resolution Unit associates has also taken place to ensure associate absence (whether planned or unplanned) will not prohibit timely responses to our provider.

2. Provider Complaints Received by AGP's Claims Processing Department

The following deficiencies were noted when testing the ten complaints selected from the December 2012 Provider Claim Dispute Log:

- Four of the ten complaints were not resolved within 30 days and AGP failed to inform the provider that a decision would be made within 60 days of receipt.

- Three of the ten provider complaints were not resolved within 60 days and no written agreement with the provider was executed to allow for additional time to resolve the complaint.

Management Comments
As to the first and second bulleted comments above, AGP concurs. AGP implemented extension letter automation on 8/15/13 for the 30 & 60 day extension letter requirement. A report now exists to track and ensure extension letters are generated. If AGP expects resolution to exceed 60 days, a procedure was implemented so that in advance of reaching 60 days, an outreach is made to the provider and a confirmation of understanding email is sent.

B. Provider Complaints Received by TDCI

TDCI offers to providers a complaint process for disputes with TennCare MCOs. Complaints may involve claims payment accuracy and timeliness, credentialing

procedures, inability to contact or obtain assistance from the MCO, miscommunication or confusion around MCO policy and procedures, etc. When a provider complaint is received, TDCI forwards the complaint to the MCO for investigation. The MCO is required to respond in writing within 14 days to both the provider and TDCI to avoid assessment of liquidated damages pursuant to the "On Request" report requirements of the CRA. If the provider is not satisfied with the MCO's response to the complaint, the provider may seek other remedies to resolve the complaint, including but not limited to, requesting a claims payment dispute be sent to an independent reviewer for resolution or pursuing other available legal or contractual remedies.

For the period January 1 through December 31, 2012, TDCI received and processed 55 provider complaints against AGP. The responses by AGP to providers were categorized by TDCI in the following manner:

Previous denial or payment upheld	12
Previous denial or underpayment reversed in favor of the provider	31
Previous denial or underpayment partially reversed in favor of the provider	7
Responses to issues other than claims payment	4
Provider complaint withdrawn by provider	1

TDCI judgmentally selected 10 of these provider complaints for review. The issues raised by the providers were analyzed and questions were posed to AGP for response. Emphasis was placed on discovering deficiencies in the AGP's claims processing system or provider complaint procedures. The detailed review of the provider complaints, including TDCI questions and AGP responses, can be found in Appendix 1 of this report. The following is a summary of the significant issues in AGP's claims processing and provider complaint procedures that were noted in the review:

- One claim was incorrectly denied by AGP for exceeding the timely filing limit of 120 days; however, AGP received the claim 115 days after the date of service.

- One emergency room claim processed by AGP incorrectly paid $50 as non-emergent even though the diagnosis was an emergency as defined by AGP. A subsequent reprocessing project by AGP incorrectly reversed the payment on this claim to zero dollars. The provider resubmitted the claim and AGP denied the claim for exceeding the timely filing limits. After the provider complained to TDCI, AGP reprocessed and correctly paid the claim at the contracted emergency diagnosis rate.

  Management Comments
  As to the first and second bulleted comments above, AGP concurs. AGP has updated its timely filing claims processing instructions. Additionally as to second

bulleted comment above, AGP re-educated its claims associates on the processing of emergent/non-emergent claims.

C. Independent Reviews

The independent review process was established by Tenn. Code Ann. § 56-32-126(b)(2) to resolve claims disputes when a provider believes a TennCare MCO has partially or totally denied claims incorrectly. TDCI administers the independent review process, but does not perform the independent review of the disputed claims. When a request for independent review is received, TDCI determines that the disputed claims are eligible for independent review based on the statutory requirements (i.e. the disputed claims were submitted for independent review within 365 days from the date the MCO first denied the claims). If the claims are eligible, TDCI forwards the claims to a reviewer who is not a state employee or contractor and is independent of the MCO and the provider. The decision of the independent reviewer is binding unless either party to the dispute appeals the decision to any court having jurisdiction to review the independent reviewer's decision.

For the period January 1 through December 31, 2012, 14 independent reviews were initiated by providers against AGP. The following is a summary of the reviewer decisions:

Reviewer decision in favor of the provider	1
AGP settled with provider upon submission of the independent review	7
Reviewer decision in favor of AGP	3
Review request submitted by provider was ineligible	2
Decision Pending as of Field Examination Date	1

TDCI judgmentally selected five independent reviews for testing. The issues raised by the providers were analyzed and questions were posed to AGP for response. Emphasis was placed on discovering deficiencies in the AGP's claims processing system or provider complaint and appeal procedures. The detailed testing of the independent reviews, including TDCI questions and AGP responses, can be found in Appendix 2 of this report. The following issue was noted during the testing of independent reviews:

One claim incorrectly denied EPSDT service lines for other insurance. EPSDT services should not be denied on first processing for other insurance. Per CMS State Medicaid Manual section 3904.4.B, "You must pay and chase in situations where the claim is for prenatal care for pregnant women or preventative pediatric services including EPSDT services that are covered under the State plan." AGP has changed claims adjudication processes to correctly pay EPSDT services on first processing even if other

insurance is suspected.

Management Comments
AGP concurs. AGP identified the error and reprocessed the claim accordingly. AGP's claims processing instructions were reviewed to ensure they were in compliance with COB guidelines.

D. 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.

On March 15, 2013, AGP submitted for prior approval an update to the provider manual. The update was approved by TDCI on March 27, 2013.

E. Provider Agreements

Agreements between an HMO and 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 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 provider.

Per Section 2.12.2 of the CRA, all template provider agreements and revisions thereto must be approved in advance by TDCI, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Additionally, Section 2.12.7 of the CRA reports the minimum language requirements for provider agreements.

A total of ten executed provider agreements were judgmentally selected from the 36 claims tested above in section VI.D. The provider agreements selected included contracts executed by the subcontractors Block Vision and TNC. The following deficiencies were noted:

- The executed agreement between Block Vision and a national vision service provider did not contain all of the language requirements of Section 2.12.7 of the CRA. Additionally, the executed agreement was never submitted for prior

approval to TDCI per Tenn. Code Ann. § 56-32-103(c)(1). AGP researched and found that another national vision service provider contract did not contain all of the language requirements of Section 2.12.7 of the CRA and was not submitted to TDCI for prior approval.

- A template agreement to be used by TNC to contract with NEMT providers was submitted and approved by TDCI on October 7, 2008. However, TNC did not utilize the prior approved template agreement when contracting with a provider but instead executed an earlier draft version of the provider agreement which did not meet all of the language requirements of Section 2.12.7 of the CRA.

  Management Comments
  As to the first bulleted comment above, AGP concurs. Block Vision notified AGP on November 11, 2013 of the amended agreement with Wal-Mart that includes the CRA required language. Block Vision has amended its agreement with the other national vision service contract provider to include the CRA required language.

  As to the second bulleted comment above, AGP concurs. TNC developed an Amendment-By-Notification (ABN) to ensure provider agreement compliance with all of the language requirements of Section 2.12.7 of the CRA. The ABN was approved by the TDCI on December 20, 2013. The ABN was forwarded to providers on January 10, 2014.

F. Provider Payments

Capitation payments to providers were tested during 2012 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.

G. 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, Section 2.26.3 of the CRA requires all subcontractor agreements and revisions thereto 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.

Five subcontracts were judgmentally selected for testing. No deficiencies were identified in the subcontracts tested.

H. Subcontractor Monitoring

The CRA between AGP and the TennCare Bureau allows AGP to delegate activities to a subcontractor. AGP is required to reduce subcontractor agreements to writing and specify the activities and report responsibilities delegated to the subcontractor. AGP should monitor the subcontractor's performance on an ongoing basis. Also, AGP should identify any deficiencies or areas for improvement and determine the appropriate corrective action as necessary. Section 2.26.1 of the CRA states, "If the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6." Additionally Section 2.26.7 requires AGP to ensure that subcontractors comply with all applicable requirements of the CRA. Federal and state requirements include, but are not limited to, specific regulations regarding non-discrimination, conflicts of interest, lobbying, and offer of gratuities.

TDCI requested AGP to provide documentation of its efforts to monitor subcontractor's compliance with CRA requirements. No deficiencies were noted during the review of AGP's subcontractor review tools and monitoring efforts.

I. Non-discrimination

Section 2.28 of the CRA requires 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 2.28 of the CRA.

J. 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.

The Internal Audit Department of AGP's parent company, AMERIGROUP Corporation, performs engagements of AGP specific to its TennCare operations. Reports released by the Internal Audit Department related to Tennessee during 2012 including the following engagements:

- Tennessee Conflict of Interest
- Inbound Claims Process
- Political Contributions

The observations noted in these reports were considered by TDCI during the current examination.

K. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., Title 56, Chapter 11, Part 2 – 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 is domiciled in the State of Tennessee and therefore the filing is regulated in Tennessee. No discrepancies were noted in the annual holding company registration filing for AGP received in 2013 for the calendar year 2012.

L. Health Insurance Portability and Accountability Act (HIPAA)

Section 2.27 of the CRA requires AGP to comply with requirements of the Health Insurance Portability and Accountability Act of 1996, including but not limited to the transactions and code set, privacy, security, and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data partner situations required under the regulations.

AGP and subcontractor's information systems policies and procedures were reviewed in relation to the HIPAA requirements of the CRAs. The policies and procedures of AGP's subcontractor, TNC, did not include specific requirements for TNC personnel to contact AGP and the TennCare privacy officer immediately upon becoming aware of any unauthorized use or disclosure of enrollee protected health information not otherwise permitted or required by HIPAA per section 2.27.8 of the CRA.

Management Comments
AGP concurs. TNC developed a breach notification policy whereby AGP and the TennCare Privacy Officer are immediately notified upon TNC becoming aware of any unauthorized use or disclosure of enrollee protected health information not otherwise permitted or required by HIPAA per Section 2.27.8 of the CRA.

M. Conflict of Interest

Section 4.19 of the 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 CRA 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 CRA 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 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 CRA.
- The organizational structure of AGP includes a compliance officer who reports to the President/CEO.
- 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.
- Internal audits are performed to determine compliance with the conflict of interest requirements of the TennCare CRA.

TDCI noted no material instances of non-compliance with conflict of interest requirements for AGP during the examination test work.

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

Appendix 1

Details of the Review of Provider Complaints Submitted to TDCI (See Section VIII.B.)

Please note that AGP's comments below are unedited and reported verbatim as provided in writing during the examination.

2012.101 – Provider complained that the claim was incorrectly denied because no authorization was requested.

- AGP Response: AGP upheld the denial.
    - TDCI's Follow-up Question: Were authorizations in the claims processing system for this date of service? TDCI found no authorizations in the claims processing system for this date of service.
- AGP's Comments/Follow-up: No follow-up required.

2012.114 – Physician group complained that AGP requested a refund for a previously paid claim.

- AGP Response: AGP paid the claim in error.
    - TDCI's Follow-up Question: Why was the claim originally paid?
- AGP's Comments/Follow-up: AGP manually processed and paid claim in error for hospice services provided to a Medicare member. Medicare does not cover hospice services. Claim error was identified and recouped from provider and analyst educated.

2012.173 – Provider complained that AGP is seeking recoupment of claim payment for an enrollee that was eligible at the time the claim was submitted but was subsequently retroactively disenrolled from the TennCare program.

- AGP Response: AGP upheld the denial because the member was not eligible.
    - TDCI's Follow-up Question: How was the disenrollment discovered?
- AGP's Comments/Follow-up: AGP reported that monthly eligibility checks are ran to determine if members were eligible on date of service.

2012.001 – Physician group claim was incorrectly denied for no prior authorization even though the patient was presented at the emergency room.

- AGP Response: AGP reversed and paid the claim.

  - TDCI's Follow-up Question: Why did the first processing miss the emergent diagnosis?

- AGP's Comments/Follow-up: Claim was submitted by non-par provider with place of service 22. Research later discovered patient was presented through the emergency room and the diagnosis was on the ER diagnosis code list.

- Additional AGP Comment: The physician claim was denied for no prior authorization. The claim was submitted from a non-par provider with a place of service 22 (outpatient). Non-par providers are required to obtain a preauthorization for services. Upon receipt of the claim, AGP had no knowledge that the patient initially presented in the emergency room and was moved to observation. The provider was told when they called AGP's Provider Services Department that the place of service was incorrect for an emergent service. An appeal was made on January 12, 2012 and the denial was upheld due to the POS 22 not having an authorization. Upon receipt of the State Complaint 2012.001, medical records were reviewed and the original denial was overturned, as the submitted medical records clearly indicated the member presented to the emergency room.

2012.179 – Facility complained that its claim was incorrectly denied for untimely filing.

- AGP Response: AGP reviewed the complaint and reversed and paid the claim.

  - TDCI's Follow-up Question: TDCI asked AGP to explain the reason for the original claim denial. Additionally, TDCI questioned why AGP reversed the denial and subsequently paid the claim.

- AGP's Comments/Follow-up: Original denial was upheld in error. Claim was actually received 115 days from date of service which was within the 120 day filing limit. Claim was manually processed. AGP reversed and paid claim.

2012.188 – Physician group complained that AGP incorrectly denied a claim for untimely filing.

- AGP Response: AGP reviewed the complaint and reversed and paid the claim.

  - TDCI's Follow-up Question: What is project SFC2044443001326605 that was referenced by the provider? What is the basis for the reversal of AGP's decision to deny the claim?

- AGP's Comments/Follow-up: ER claims were processed and only paid $50 per the Emergency Department Policy reimbursement for CPT Codes 99281 – 99285 and the claim meets ED criteria, the participating provider is reimbursed in accordance with their AGP contract. Claims were reprocessed to pay accordingly. Upon, further review, AGP provided the correct project number SF20130110110190174834; the project was initiated due to provider's complaint regarding the incorrect timely filing denial. In its review, AGP reversed the denial due to the claim having been received within 120 days of the date of service.

Therefore, the claim had been manually denied in error. The project was initiated for 6,757 ER claims that were incorrectly paid at the non-ER rate of $50 due to a configuration error. Upon, configuration fix, all 6,757 claims were reprocessed for additional reimbursement. Of the 6,757 claims reprocessed, the Macro incorrectly processed 696 claims for recoupment. All 696 claims have been reprocessed for payment.

2012.322 – Physician group complained that AGP paid claims at less than the contracted rate.

- AGP Response: AGP reversed and reprocessed the claims.
    - TDCI's Follow-up Question: Was the Explanation of Payment (EOP) submitted by the provider incorrect on the first submission?
- AGP's Comments/Follow-up: Yes, the EOP was incorrect. AGP provided copy of the EOP.

2012.014 – Provider complained that AGP would not credential him because the physician panel was closed.

- AGP Response: AGP reversed the decision.
    - TDCI's Follow-up Question: What are the criteria that AGP used to access into the network?
- AGP's Comment/Follow-up: AGP TN's procedures are designed to continually assess the adequacy of its network. AGP selects and contracts a provider network that is adequate to assure access to primary care, specialty care and behavioral healthcare services. To help ensure that the network meets network adequacy standards, a monthly network access credentialing grid is generated to identify current specialties and counties for which AGP is accepting credentialing applications. In identifying the specialties and counties, Provider Relations considers, any deficiencies in geographic access as identified by standards include in the CRA, the number and location of providers accepting new members, the number and location of providers available to meet specific demographic needs, and network intelligence as identified by Provider Relations staff. The provider was admitted to the network on 3/20/12. No additional information is needed.

2012.054 – Hospital complained that its claim was incorrectly denied for timely filing.

- AGP Response: AGP reversed the denial.
    - TDCI's Follow-up Question: Why was claim denial reversed?
- AGP's Comment/Follow-up: Original claim was manually rejected paper claim in error for invalid NPI so it never made it into Facets. Second submission denied incorrectly for timely filing. The claim was adjusted and processed on 4/4/12.

2012.069 - Physician group complained that AGP incorrectly denied claim because of the procedure code modifier billed.

- AGP Response: AGP reversed the claim.
    - TDCI's Follow-up Question: Why was the denial reversed on complaint that modifier 26 and 59 are no longer included in other service line?
- AGP's Comment/Follow-up: Claim was reprocessed due to decision by AGP. The plan will be to turn off the rule requiring record submission with modifier 59 for all markets. AGP had required medical records for modifier 59, but post-audit procedures will be performed for this modifier.

Appendix 2

Details of Testing of Independent Reviews (See Section VIII.C.)

Please note that AGP's comments below are unedited and reported verbatim as provided in writing during the examination.

IR 12-001 - Issue and Independent Review (IR) Decision: A hospital alleged AGP incorrectly denied claims for medical necessity. The Independent Reviewer issued a decision in favor of AGP.

- TDCI's Follow-up Question: N/A.

IR 12-006 - Issue and IR Decision: A provider's claim was denied for no authorization. AGP reversed and paid the claim before the IR decision was rendered because the provider had "gold card status".

- TDCI's Follow-up Question: Why did AGP reverse the denial? What is gold card status?
    - AGP Response: A Gold card status is a VIP provider where prior authorization is not required for any services. Original denial on claim was related to claim check edits, not authorization.

IR 12-007 - Issue and IR Decision: Hospital alleged AGP incorrectly denied an inpatient rehabilitation claim. AGP reversed and paid the claim before the IR decision was rendered.

- TDCI's Follow-up Question: Why did AGP reverse the denial? Additionally, what factors changed since AGP also upheld the denial through AGP's claims appeal process.
    - AGP Response: AGP reversed its original decision based on the recommendation of AGP's Legal Department to pay for services rendered. The Legal Department reviewed the attorney letter and the records and found the arguments for payment compelling to allow the payment for the claim.

IR 12-015 – Issue and IR Decision: Provider disputed AGP's denial of claim for timely filing. AGP was not the primary insurer on the claim. AGP reversed and paid the claim before the IR decision was rendered.

- TDCI's Follow-up Question: What was AGP's basis for reversing the claim denial? Was it appropriate to deny this claim for timely filing?
    - AGP Response: Services were initially submitted on claim with primary carrier's EOP. Claim was partially denied because the primary EOP listed a denial code without a description of the denial code. Benefits were later coordinated and the claim reprocessed for payment based on the fact the updated primary EOP was

submitted with an explanation of the denial code. The claim was received within 120 days of the primary EOP. Therefore, a TFO denial would not have been correct.

After further review, it was determined the claim incorrectly denied EPSDT lines for other insurance. The claim on first processing should have paid as a "pay and chase" claim. AGP has changed claims adjudication processes to correctly pay EPDST services on first processing even if other insurance is suspected.

IR 12-032 – Issue and IR Decision: DME provider disputed payment for 30% of billed charges when the contract requires payment of 70% of eligible charges when CMS rate is not listed for the service billed. AGP reversed and paid the claim before the IR decision was rendered.

- TDCI's Follow-up Question: Did the provider first submit this dispute to AGP as a claims appeal? Why was the claim not paid according to the contract when it was first processed?

    - AGP Response: Claim was originally paid at 30% of billed charges from a project found dated 12/07/11. Payment dispute was received on 2/7/12. Supporting documentation was not received prior to/for the appropriate reimbursement on previous claim.

      After further review, AGP determined the provider never submitted a written appeal, instead they called our Provider Service Unit. The claim, when originally received by AGP, was manually matched to an incorrect provider record, resulting in a lesser reimbursement. Shower chairs are not covered under AGP's standard policies. However, TennCare does allow coverage for Shower Chairs and on 10/5/10 FACETS was configured to allow payment, with a retro-effective date of 4/1/2007. AGP's DME vendor also covers Shower Chairs for TennCare members. The claim prompting this inquiry was manually denied in error.

Appendix 3

Previous Examination Findings

The previous examination findings are provided for informational purposes. The following were financial, claims processing and compliance deficiencies cited in the examination by TDCI for the period January 1 through December 31, 2010:

A. Financial Deficiencies

No reportable deficiencies were noted.

B. Claims Processing Deficiencies

1. AGP failed to meet the claims processing requirements of Section 2.22.4 of the CRA for nursing facility claims and for HCBS claims for the months of May, June, July, September, October, and November of 2010.

2. AGP failed to achieve the required claims payment accuracy rate of 97% per Section 2.22.6 of the CRA for all claims processed in February 2010. AGP failed to achieve 97% claims payment accuracy for only long term care nursing facility claims for the months of June, July, October, November, and December 2010.

3. The following deficiencies were noted when testing a sample of claims from AGP's and the subcontractor's fourth quarter claims payment accuracy reports:

   - AGP reported a manual error for a claim processed in December 2010; however, the claim was not corrected in the claims processing system until May 18, 2011.

   - AGP reported payment errors for fourteen long term care nursing facility claims processed in December 2010. The errors were the result of a configuration issue causing AGP to not correctly apply the patient liability when determining the amount to be paid on the claims. The fourteen claims found during AGP's claim payment accuracy testing were reprocessed and corrected in a timely manner by AGP. However, AGP failed to investigate and identify all claims affected by this configuration issue.

   - AGP should improve procedures to analyze errors discovered during claims payment accuracy testing. In addition to correcting claims found in error in a timely manner, AGP should determine if any other claims are affected by the error.

4. A Medicare claim was erroneously reported in the TennCare claims data file

submitted to TDCI for prompt pay compliance testing. No explanation of the error was provided. The accurate submission of data files for prompt pay testing is critical in the determination of compliance with the prompt pay requirements of Tenn. Code Ann. § 56-32-126(b)(1) and Section 2.22.4 of the CRA.

5. Two of 133 claims selected for testing were denied with the explanation "included in behavioral health case management rate and services paid via bi-weekly settlement." A denied status was reported for both claims in the prompt pay data files. The status of both claims should have been reported as "capitated". The inaccurate reporting of claims status can affect the determination of prompt pay compliance. Additionally, the inaccurate reporting of claim status will affect the accuracy of encounter data files relied upon by the TennCare Bureau.

6. For three of five enrollees selected for copayment testing, AGP incorrectly applied copayments on a total of eleven claims.

Findings 1, 2 and 3 have been repeated in the current examination.

C. Compliance Deficiencies

1. Five complaints were selected for testing from the December 2010 log of provider complaints received via the TennCare Bureau. AGP did respond to providers within 30 days. However, the following deficiencies were noted:

   - A provider complaint received December 6, 2010, involved a claim with dates of service in May 2008 for a member that was determined retroactively eligible by the TennCare Bureau. AGP agreed the claim should be paid. AGP had not reprocessed the claim for payment as of fieldwork in May 2011. AGP notes that it is difficult to price and pay a claim with dates of service over two years old.

     The delay in payment does not appear warranted. Even though these situations are rare, AGP should develop procedures to resolve these types of claims disputes.

     Additionally, AGP should have documented in written correspondence that the provider agreed to the resolution of the claim dispute exceeding 60 days as required byTenn. Code Ann. § 56-32-126(b)(2)(A).

   - A provider complaint received December 16, 2010, involved a claim that was denied for evidence of other insurance coverage by the member. Last contact with the provider was a phone message on December 29, 2010. As

of fieldwork in May 2011, the provider log indicates the complaint is still open.

AGP should formalize decisions to the provider in written communications in order to satisfy requirements of Tenn. Code Ann. § 56-32-126(b)(2)(A).

2. Ten provider claims disputes were selected for testing from the December 2010 log of provider complaints received by AGP's claims processing department. AGP did respond with an acknowledgement letter of receipt to all ten provider complaints within 30 days. The following deficiencies were noted:

   - Five of the ten complaints selected for testing were not resolved within 30 days and AGP failed to inform the provider that a decision would be made within 60 days of receipt. Tenn. Code Ann. § 56-32-126(b)(2)(A) requires AGP to inform the provider if AGP determines it needs longer than 30 days to completely respond to the provider complaint and that a decision shall be made within 60 days of receipt.

   - Four of the ten provider complaints selected for testing were not resolved within 60 days and no written agreement with the provider for additional time was made. Tenn. Code Ann. § 56-32-126(b)(2)(A) requires AGP to reach an agreement in writing for additional time to resolve the complaint with the provider if resolution of the provider complaint will exceed 60 days.

   - For three of the ten provider complaints selected for testing, the paid date in AGP's claims processing system was one day later than the dispute decision date recorded on the provider complaint log. The provider complaint log should accurately record dispute decision dates in order to ensure compliance with the time frames of Tenn. Code Ann. § 56-32-126(b)(2)(A).

   - Three of the ten provider complaints selected for testing were originally denied because the claims for HCBS services exceeded units authorized by AGP for daily or weekly limits. When these three claims were originally denied, AGP's claim adjudicators reviewed the authorization limits based on the enrollee's plan of care in the care manager system and found that the provider had not followed the date and time specific requirements determined by the enrollee. Upon receipt of the provider complaint disputing the denials, AGP reversed their original denial and paid the claim even though the provider had not delivered HCBS services according to the enrollee's plan of care. The issues raised by these complaints would not have occurred if AGP had required the subcontractor to enforce preferred scheduling as required by the CRA.

3. The following is a summary of the significant issues noted in AGP's claims processing and provider complaint procedures from the review of provider complaints submitted to TDCI:

- For one of the twelve provider complaints selected for testing, a provider complained that AGP incorrectly denied a claim with the explanation "service is not allowed under contract." AGP upheld its decision on an initial complaint by the provider. However, AGP reversed its decision after the provider submitted the complaint to TDCI. AGP failed to recognize that it had granted a prior authorization for the service even though it was not covered under the provider's contract. AGP should update procedures to ensure that prior authorizations granted are for services covered under the provider's contract. Additionally, AGP should have recognized the error in the review process of the first complaint by the provider.

- For one of the twelve provider complaints selected for testing, AGP overturned its decision to deny the claim on May 18, 2010, in response to the provider complaint; however, the payment to the provider was not made until after the provider made a second complaint against AGP to TDCI on August 19, 2010. AGP paid the overturned claim on August 26, 2010. Upon a reversal of denial, AGP should ensure that claims are promptly reprocessed for payment.

4. For one of the six independent reviews selected for testing, a provider submitted an independent review which alleged AGP incorrectly denied a duplicate service performed on the same day even though the service was appropriately billed with a modifier indicating it was a distinct procedural service. Initially the provider disputed AGP's denial though AGP's provider complaint process. AGP upheld its denial of the service. However, upon submission to independent review, AGP reversed its previous denial before the independent reviewer's decision was rendered. AGP should have recognized the error in the review process when the dispute was first submitted through AGP's provider complaint process.

5. A total of fifteen executed provider agreements were judgmentally selected for testing from the provider network directory files submitted by AGP directly to the TennCare Bureau. One of the fifteen executed provider agreements did not agree with the TDCI prior approved template.

   AGP should ensure that all provider agreements and amendments have been prior approved by TDCI before execution.

6. Ten subcontracts were judgmentally selected for testing. The following deficiencies were identified in the subcontracts tested:

   - Four of the subcontracts were not submitted to TDCI or TennCare for prior approval.

   - An amendment to one approved subcontractor template was never submitted to TDCI or the TennCare Bureau for prior approval.

AGP should ensure that all subcontract agreements and amendments have been approved by TDCI and TennCare before execution.

7. The following deficiencies were noted during the review of AGP's subcontracting monitoring efforts:

   - AGP did not demonstrate monitoring or coordination efforts with direct service subcontractors related to non-discrimination requirements per Section 2.28.2 of the CRA.

   - AGP did not demonstrate monitoring efforts of subcontractors related to conflict of interest requirements of the CRA. Per Section 2.26.7 of the CRA, AGP is required to ensure that subcontractors comply with Section 4.19 of the CRA.

   - AGP did not confirm that subcontractors submitted quarterly disclosures required by Section 4.19 of the CRA. This section requires quarterly reporting to the TennCare Bureau, which includes a list of any state or federal officer or employee of the State of Tennessee as well as any immediate family member of a state or federal officer or employee of the State of Tennessee who receives wages or compensation from the subcontractor.

   - AGP did not demonstrate monitoring efforts of subcontractors to ensure compliance with offer of gratuities requirements of the CRA. Section 4.23 of the CRA requires subcontractors to certify that no elected, appointed or employed person of the State or Federal government has or will benefit financially due to influence as a result of the contract between AGP and the TennCare Bureau.

   - AGP did not demonstrate monitoring efforts of subcontractors to ensure compliance with lobbying requirements of the CRA. Section 4.24 of the CRA requires subcontractors to certify that federal funds have not been used for lobbying in accordance with 42 CFR Part 93 and 31 USC 1352.

   - AGP did not confirm that subcontractors disclosed lobbying activities per Section 4.24 of the CRA. This section requires the subcontractor to disclose any lobbying activities using non-federal funds in accordance with 45 CFR Part 93.

8. The following deficiencies related to the CHOICES program administration were noted :

   - AGP failed to meet the claims payment accuracy requirements of Section 2.22.6 of the CRA for the months of June, July, October, November and

December 2010 for nursing facility claims. Corrective action plans submitted by AGP noted the primary reasons for the failure were:

- AGP incorrectly calculated the patient liability in determination of the total amount to be paid for certain nursing facility claims, and
- AGP failed to pay the contracted rate as a result of fee tables which were not updated for rate changes.

- As of field work in June 7, 2011, AGP has not required its EVV subcontractor to enforce the preferred scheduling determined by the enrollee's plan of care. Without the enforcement of preferred scheduling, providers are allowed to bill for services contrary to the date and time specified in the enrollee's plan of care.

Findings 1 through and 6 have been repeated in the current examination.