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, 2010
THROUGH DECEMBER 31, 2010

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DATE: November 9, 2011

The Financial and Compliance Examination and Market Conduct Examination of the TennCare Operations of AMERIGROUP Tennessee Inc., Nashville, Tennessee, was completed June 7, 2011. The report of this examination is herein respectfully submitted.

I. FOREWORD

On, March 10, 2011, 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 the TennCare Operations. Fieldwork began on May 9, 2011, and ended on June 7, 2011.

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 for its TennCare operations of AGP's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of the TennCare operations of AGP was conducted jointly by TDCI and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 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, 2010.

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, and the demonstration of compliance with non-discrimination reporting 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 November 1, 2007, AGP purchased substantially all of the assets of Memphis Managed Care Corporation (MMCC) d/b/a TLC Family Care Health Plan (TLC) and TLC's wholly-owned subsidiary MidSouth Health Solution, Inc. Also, effective on October 31, 2007, the TennCare Bureau consented to the assignment by MMCC and the assumption by AGP of all of MMCC's rights and obligations under the TennCare Agreement to AGP. TLC's existing administrative

services only arrangement for the West Tennessee Grand Region terminated on October 31, 2008.

AGP contracts with the parent, AMERIGROUP Corporation, to provide management services. The management agreement provides that AMERIGROUP Corporation shall perform all administrative and support services necessary for the operation of AGP. These services include, but are not limited to, finance, management information systems, claim administration, telephonic member and provider services support, legal, regulatory, and provider credentialing.

The officers and directors or trustees for AGP at December 31, 2010, were as follows:

Officers for AGP

Alvin Brock King, President/CEO
William George Runyon, Vice President/CMO
Edna Laverne Willingham, Vice President/COO
Nicholas Joseph Pace, II, Vice President/Secretary
Margaret Mary Roomsburg, Vice President/Asst. Secretary
Richard Charles Zoretic, Vice President/Asst. Secretary
Scott Wayne Anglin, Vice President/Treasurer
Karen Lint Shields, Vice President/Asst. Treasurer
James Ward Truess, Vice President/Asst. Treasurer

Other Officers for AGP

Linda Kaye Whitley-Taylor, Vice President
William Gardner Wood, M.D., Chief Medical Officer

Directors or Trustees for AGP

Charles Brian Shipp
Alvin Brock King
Nicholas Joseph Pace, II

B. Brief Overview

Effective April 1, 2007, AGP entered into a full-risk contract with the TennCare Bureau to provide health services to enrollees in the Middle Tennessee Grand Region in exchange for a per member per month capitation payment. As of December 31, 2010, AGP had approximately 202,000 TennCare enrollees for the Middle Tennessee Grand Region.

Effective March 1, 2010, the CRA between AGP and the TennCare Bureau was amended for the implementation of the CHOICES program. CHOICES is

TennCare's program for long-term care services. Long-term care services include care in a nursing home and certain services to help a person remain at home or in the community. Home and Community Based Services (HCBS) are services that include help doing everyday activities that enrollees may no longer be able to do for themselves as they grow older or if they have a physical disability that prevents them from bathing, dressing, getting around their home, preparing meals, or doing household chores. As of December 31, 2010, AGP had approximately 4,600 TennCare enrollees assigned to the CHOICES program for the Middle Tennessee Grand Region.

In addition to TennCare operations, in January 2008, AGP began offering a Medicare Advantage plan for those who are eligible for both Medicaid and Medicare. For the year ending December 31, 2010, AGP reported Medicare premiums totaling $16,750,528 with 1,389 members.

C. Claims Processing Not Performed by AGP

TennCare has contracted with other organizations for the administration and claims processing of these types of services:

- Dental, and
- Pharmacy.

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

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

IV. 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 April 1, 2007 through March 31, 2008:

A. Financial Deficiencies

1. A review of the payments for medical services and adjustments by AGP from April 1, 2008, through October 31, 2008, for dates of services before April 1, 2008, determined that the incurred but not reported (IBNR) estimated amount payable for TennCare operations in the Middle Tennessee Grand Region was understated as of March 31, 2008 by $4,954,230. AGP has adjusted IBNR after

the examination period by increasing claims margins from 7% to 7.5%. Until a significant history of medical claims payments have occurred, AGP should conservatively report medical claims payable.

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

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

4. The administrative allocations for taxes incurred by the parent and "Cost of Capital" should not be charged to AGP. In discussions subsequent to fieldwork, management agreed with the conclusions of TDCI and agreed to eliminate allocations for taxes incurred by the parent and "Cost of Capital" retroactively to December 31, 2007.

None of the previous findings have been repeated in this report.

B. Claims Processing Deficiencies

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

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

3. For the combined operation of the West and Middle Tennessee Grand Regions, AGP did not process TennCare claims timely in accordance with Tenn. Code Ann. § 56-32-126(b)(1) for the months of February 2008 and April 2008. AGP

was put on monthly testing for three months and consistently achieved compliance beginning May 2008.

4. AGP was awarded a TennCare contract for the Middle Tennessee Grand Region beginning April 1, 2007. A prior site visit of AGP was conducted by TDCI on August 27 through 29, 2007 to assess claims processing problems after implementation on April 1, 2007. AGP's Middle Tennessee operations experienced claims processing errors and configuration challenges resulting in delayed payments, inaccurate payments, and incorrect denials of provider claims. The recommendations and findings of the prior site visit were reviewed during the current examination. AGP has devoted significant resources to correct post implementation issues, however, deficiencies remain as revealed by self-reported claim payment accuracy percentages and claims tested by TDCI and the Comptroller.

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

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

7. For AGP's TLC operations, procedures for testing claims payment accuracy are deficient because the plan did not maintain the testing results of each attribute required per Section 2.9.m.2 of the CRA for the West Tennessee Grand Region.

8. For AGP's Middle Tennessee operations, procedures for testing claims payment accuracy are deficient because the plan did not maintain the testing results of each attribute required per Section 2.22.6.4 of the CRA for the Middle Tennessee Grand Region.

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

10. For 14 of the 115 claims selected for testing from claims processed by AGP's Middle Tennessee operations, adjudication errors by AGP were discovered by TDCI and Comptroller.

11. For eight of the 60 claims selected for testing from claims processed by AGP's TLC West Tennessee operations, adjudication errors by AGP were discovered by TDCI and the Comptroller.

12. For five of the 60 claims selected for testing from claims processed by AGP's TLC West Tennessee operations, pricing accuracy errors by AGP were discovered by TDCI and The Comptroller.

Findings six and ten have been repeated in this report.

C. Compliance Deficiencies

1. For one of five provider complaints selected for testing for AGP's TLC West Tennessee operations, the plan incorrectly denied a medical claim for timely filing upon resubmission.

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

3. For AGP's Middle Tennessee operations, TDCI and the Comptroller selected as a test month provider complaints received by the plan in March 2008. The response by AGP to twelve complaints exceeded 30 days and one complaint exceed 60 days in violation of Tenn. Code Ann. § 56-32-126. For the twelve complaints that exceeded the 30 day response deadline, no acknowledgement was communicated to the provider that a response would exceed 30 days. For the one complaint that exceeded a 60 day response deadline, no agreement was made in writing with the provider noting that the response would exceed 60 days.

4. For AGP's Middle Tennessee operations, TDCI and the Comptroller selected twelve complaints for further testing. For eight of the twelve complaints tested, the date in the claims processing system for the "remit date" or the resolution date did not match the "End Date" or "Response Date" on the complaint log. The plan must ensure the complaint logs correctly report resolution or response dates to ensure compliance with Tenn. Code Ann. § 56-32-126.

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

   - The provider manual was approved by TDCI on January 2007, however the version communicated to providers on the company website does not agree with the approved version.

- On the company website, providers were informed of 36 updates to the provider manual as of July 2008. These updates to the provider manual should be submitted as material modifications to AGP's operational documents in accordance with Tenn. Code Ann. § 56-32-103(c)(1).

- All of AGP's provider agreements incorporate by reference the requirements of the provider manual. Updates to the provider manual require AGP to meet contractual provider notification requirements. Eleven provider agreements were tested to determine if AGP complied with notification requirements of Section 2.12.7.35 of the CRA for the Middle Tennessee Grand Region. None of the eleven provider agreements files contained evidence of notification requirements.

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

7. For the period ending December 31, 2007, AGP had not complied with Section 2-10.h.4. of the CRA for the West Tennessee Grand Region and Section 2.21.10.2 of the CRA for the Middle Tennessee Grand Region which require audits of the plan be subject to prior approval of the Comptroller of the Treasury and to be submitted on the standard "Contract to Audit Accounts" agreement.

8. TDCI recommends that AGP's annual review of political contributions incorporates and documents specific testing of the conflict of interest provisions of Section 4-7. of the CRA for the West Tennessee Grand Region and Section 4.19 of the CRA for the Middle Tennessee Grand Region.

Findings two, three, four, and six have been repeated in this report.

V. 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.

B. Claims Processing Deficiencies

1. AGP failed to meet pay 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.

   (See Section VII.A. of this report)

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

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

3. For the claims selected for verification from AGP's and the subcontractor's fourth quarter claims payment accuracy reports, the following deficiencies were noted:

   - 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 a payment error for fourteen long term care nursing facility claims processed in December 2010. The error was the result of a configuration issue in that AGP had not correctly applied the patient liability in determination of 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.

   (See Section VII.C.3. of this report)

4. For one of the ten vision claims selected for testing, the claim did not represent a claim for TennCare services. The claim reported in the claims data file submitted to TDCI is actually for the Medicare plan offered by AGP. No explanation of the error has been provided. The accurate submission of data files for prompt pay testing is critical in the determination of compliance with prompt pay requirements of Tenn. Code Ann. § 56-32-126(b)(1) and Section 2.22.4 of the CRA.

   (See Section VII.D. of this report)

5. For two of the 133 claims selected for testing, the claims were denied with the explanation "included in behavioral health case management rate and services paid via bi-weekly settlement." The status of both claims in prompt pay data files was also reported to TDCI as denied. 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.

   (See Section VII.F. of this report)

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

   (See Section VII.H. of this report)

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 via the TennCare Bureau to providers within 30 days. 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 written correspondence that the provider agrees that resolution of the claim dispute will exceed 60 days per Tenn. 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).

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

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.

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

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.

(See Section VIII.B. of this report)

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.

   (See Section VIII.C. of this report)

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. For one of the fifteen provider agreements selected for testing, the executed provider agreement 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.

   (See Section VIII.E. of this report)

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

   - For four of the ten subcontracts selected for testing, the subcontracts were not submitted to TDCI or TennCare for prior approval.

   - For one of the ten subcontracts selected for testing, an amendment to an 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.

   (See Section VIII.G. of this report)

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.

(See Section VIII.H. of this report)

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

   - AGP failed to meet 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 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 the subcontractor to enforce through the EVV 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.

   (See Section VIII.N. of this report)

VI. 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, 2010, AGP reported $340,305,606 in admitted assets, $189,703,065 in liabilities and $150,602,541 in capital and surplus on the 2010 Annual Statement submitted March 1, 2011. AGP reported total net income of $71,595,578 on the statement of revenue and expenses. The 2010 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 licensed in Tennessee are to be included in the calculation of net worth and deposit requirements, regardless of the reporting requirements for the NAIC statements. It should be noted that there may be timing differences between the reported annual premium revenue earned on the financial statements versus the payments made by the state.

To determine the minimum net worth requirement as of December 31, 2010, 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, 2010, or (2) to the total payments made to AGP by the TennCare Bureau for 2010 plus premium revenue from non-TennCare operations.

(1) For the period ending December 31, 2010, AGP reported TennCare premiums of $871,851,131 and Medicare premiums of $16,750,528 for a total of $888,601,659 annual premium revenue.

(2) AGP received $907,696,935 in monthly capitation payments for 2010 from the TennCare Bureau and premium revenue from non-TennCare operations of $16,750,528 for a total of $924,447,463.

Utilizing $924,447,463 as the premium revenue base, AGP's minimum net worth requirement as of December 31, 2010 is $17,616,712 [($924,447,463-$150,000,000) x 1.5% + ($150,000,000 x 4%)]. AGP's reported net worth of $150,602,541 as of December 31, 2010 is $132,985,829 in excess of statutory minimum net worth requirements.

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. Additionally with the implementation of the CHOICES program, Section 2.21.6.3.2 of the CRA required the calculation of minimum net worth to be based upon the greater of annual projected premiums for CHOICES and non-CHOICES or the prior year actual premium revenue. Annual projected premiums shall be based on the capitation payment rates for CHOICES and non-CHOICES members to be in effect upon implementation of CHOICES and projected enrollment as of the date of CHOICES implementation in the Grand Region covered by the CRA. The formula set forth in Tenn. Code Ann. § 56-32-112(a)(2) shall then be applied to the annualized projected premiums to determine the enhanced minimum net worth requirement. The annual projected premiums defined in Section 2.21.6.3.2 of the CRA was not utilized in the determination of minimum net worth requirements as of December 31, 2010. Annual projected premiums as of March 31, 2010 of $812,158,520 is less than either the reported TennCare premiums on the NAIC Annual Statement for the period ending December 31, 2010 or the total payments received by AGP from the TennCare Bureau for the calendar year 2010.

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, 2010 is $5,850,000 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 2010 of $907,696,935, AGP's required restricted deposit per Section 2.21.6.4 of CRA is $17,365,454. As of the March 1, 2011 due date for the NAIC Annual Statement for the year ending December 31, 2010, AGP had on file with TDCI safekeeping receipts totaling $17,366,000 to satisfy restricted deposit requirements.

3. Claims Payable

AGP reported $89,474,792 claims unpaid on the NAIC Annual Statement for the year ending December 31, 2010. Of the total claims unpaid reported, $87,332,554 represents 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, 2011, for dates of services before January 1, 2011, determined that the reported claims payable for TennCare operations was adequate.

B. TennCare Operating Statements

Sections 2.30.15.4.3 and 2.30.15.4.4 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.

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

C. Medical Loss Ratio Report

Section 2.30.15.3.1 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 September of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report 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 2.30.16.3 and 2.23.4.

The medical loss ratio (MLR) reports as submitted on January 21, 2011 for the period July 1, 2010, through December 31, 2010, originally reported a MLR of 80.99%. TDCI reviewed the MLR reports for the same period July 1, 2010, though December 31, 2010, submitted on July 20, 2011, which reported an adjusted MLR of 76.58%. The reason for the noted decrease in the MLR percentage is 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. Management Agreement

The management agreement between AGP and AMERIGROUP Corporation requires AGP to pay an administrative and support services fee. The management agreement provides that AMERIGROUP Corporation shall perform all administrative and support services necessary for the operation of AGP. These services include, but are not limited to, finance, management information systems, claim administration, telephonic member and provider services support, legal, regulatory,

and provider credentialing. 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 manage care services,
- Ten percent of the per member per month fee calculation above,
- Ten percent of the percentage of adjusted premium revenue calculation above, and
- Ten percent of the percentage of premium revenue if AGP renders pharmacy manages care services calculation above.

For the year ended December 31, 2010, management fees of $45,741,176 were charged to AGP by AMERIGROUP Corporation for TennCare operations. The management fee represents 5.25% of TennCare premium revenue. For the year ended December 31, 2010, management fees of $743,824 was charged to AGP by AMERIGROUP Corporation for Medicare operations. The management fee represents 4.44% of Medicare premium revenue. In addition to the management fee, AGP is responsible for paying all third party, non-affiliate costs and fees related to the services performed by AMERIGROUP Corporation for the benefit of AGP. For the year ended December 31, 2010, administrative costs other than management fees were $77,800,728, or 8.76% of total premium revenue. Total administrative costs were $124,285,730, or 13.99% of total premium revenue.

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

E. Schedule of Examination Adjustments to Capital and Surplus

As result of the examination procedures for the review of TennCare operations, no adjustments are recommended to Capital and Surplus for the period ending December 31, 2010.

VII. 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).

Pursuant to Section 2.22.4 of the CRA, AGP is required to comply with prompt pay claims processing requirements in accordance with Tenn. Code Ann.§ 56-32-126(b)(1). In addition, ATTACHMENT XI Section A.15.3 and A.15.4 of the CRA requires 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 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 2010	99%	99.9%	**Yes**
February 2010	98%	99.6%	**Yes**
March 2010	98%	99.9%	**Yes**
April 2010	99%	99.9%	**Yes**
May 2010	99%	100.0%	**Yes**
June 2010	99%	99.9%	**Yes**
July 2010	99%	100.0%	**Yes**
August 2010	99%	100.0%	**Yes**
September 2010	99%	100.0%	**Yes**
October 2010	100%	100.0%	**Yes**
November 2010	99%	99.9%	**Yes**
December 2010	99%	100.0%	**Yes**

For all TennCare operations combined, AGP processed claims timely in accordance with Tenn. Code Ann. § 56-32-126(b)(1).

TDCI tested separately the claims processed by AGP, the vision subcontractor and the NEMT subcontractor. AGP, the vision subcontractor and the NEMT subcontractor were determined to be in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for the months January through December 2010. The separate testing of prompt pay compliance by TDCI can be found at http://www.tn.gov/commerce/tenncare/promptpaybpm.shtml.

Additionally, 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 HCBS claims for services other than PERS, assistive technology, minor home modifications, and pest control submitted electronically in a HIPAA-compliant format (CHOICES):

- Ninety percent (90%) of clean claims for nursing facility services and HCBS excluding 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.

The following table represents the results of testing of prompt pay requirements for CHOICES claims for the period March 1 through December 31, 2010:

Middle Tennessee Risk – CHOICES	Clean Claims Within 14 days	Clean Claims Within 21 days	Compliance
T.C.A Requirement	90%	99.5%	
March 2010	95%	100.0%	Yes
April 2010	92%	99.9%	Yes
May 2010	83%	98.5%	No
June 2010	78%	99.5%	No
July 2010	98%	99.4%	No
August 2010	100%	100.0%	Yes
September 2010	97%	98.8%	No
October 2010	82%	98.3%	No
November 2010	85%	100.0%	No
December 2010	100%	99.9%	Yes

AGP failed to maintain prompt pay 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.

Management Comments

AGP concurs. An additional check run was added during the week for Long Term Care membership. Additionally, AGP adjusted the management of the claims inventory to ensure all items are resolved within the performance standard timeframe. These corrective actions were implemented in April 2011.

Verification of Prompt Pay Submissions

TDCI utilized the December 2010 claims data files previously submitted by AGP for prompt pay compliance to select claims for testing. TDCI judgmentally selected 133 claims from the December 2010 prompt pay data file submissions. The information submitted on the prompt pay data files was compared to the data contained in the claims processing system and the claim submitted by the provider. No discrepancies were noted.

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.

A discussion of the sample selection methodology can be found in Section VII.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 paid accurately upon initial submission. CHOICES became effective for AGP on March 1, 2010. The CHOICES implementation required AGP to separately report claims payment accuracy percentages for the following categories: Other, LTC-NF (Long Term Care Nursing Facility) and HCBS (Home and Community Based Services). However, AGP did not begin reporting the additional categories until the submission of the June 2010 claims payment accuracy report. The following table represents claims payment accuracy percentages reported by AGP for the examination period January 1, 2010 through December 31, 2010.

All Claims	Total	Other	LTC-NF	HCBS
January 2010	97%			
February 2010	**90%**			
March 2010	97%			
April 2010	99%			
May 2010	97%			
June 2010	98%	98%	**93%**	100%
July 2010	98%	99%	**94%**	98%
August 2010	98%	99%	97%	99%
September 2010	99%	99%	98%	100%
October 2010	99%	100%	**95%**	100%
November 2010	99%	100%	**95%**	97%
December 2010	97%	100%	**92%**	99%

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

Management Comments

AGP concurs. AGP submitted corrective action plans for each month that AGP fell below the 97% standard. Several key areas have been addressed through a systematic approach to issue resolution, such as automation of the patient liability calculation and admission date pricing as well as education and policy clarification for claims associates related to benefit determination, authorization and duplicate claim processing.

Additionally, Section A.19.5.2 of the CRA requires AGP to submit a separate quarterly NEMT claims payment accuracy report. The report shall be based on an audit conducted by the CONTRACTOR in accordance with Section 2.22.6 of the Agreement using a random sample of all "processed or paid" NEMT claims. The report shall include the number and percentage of NEMT claims that are paid accurately for each month in the quarter. AGP reported compliance with NEMT claims payment accuracy requirements of 97% for each quarterly report for the period January 1 through December 31, 2010.

2. 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 agreed to requirements of Section 2.22.6.4 of the CRA. These interviews were followed by a review of the supporting documentation used to prepare the 2010 fourth quarter claims payment accuracy reports. From the fourth quarter 2010 claims payment accuracy report, thirty-four claims reported as errors and ten claims reported as accurately processed were selected for verification by TDCI. From the fourth quarter 2010 NEMT claims payment accuracy report, five claims reported as accurately processed were selected for verification. Since no claims were reported as errors on the fourth quarter 2010 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.

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

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

- 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 a payment error for fourteen long term care nursing facility claims processed in December 2010. The error was the result of a configuration issue in that AGP had not correctly applied the patient liability in determination of 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.

  Management Comments

  AGP concurs. Although the manual error issue cited above was a statistical (non-payment) error, AGP understands the importance of correcting all errors that are identified timely and accurately. AGP will closely monitor and

ensure correction of all errors on a weekly basis. As to the payment issue for fourteen (14) nursing facility claims, this was a system issue that affected 1,519 claims. They have all been adjusted accordingly with full completion of this corrective action occurring in August 2011.

Additionally, AGP has implemented improved procedures to analyze errors discovered during claims payment accuracy testing. This process involves all errors and issues being tracked through completion to ensure full remediation and correction of items to include claim project numbers. Each week, open items are discussed during weekly task force meetings for remediation and resolution.

D. Claims Selected For Testing From Prompt Pay Data Files

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.

TDCI utilized the December 2010 claims data files previously submitted by AGP and the subcontractors for prompt pay compliance to select claims for testing. For each claim processed, the data files included the date received, date paid, the amount paid, and if applicable, an explanation for denial of payment. To ensure that the December 2010 data files included all claims processed in the month, the total amount paid per the data files was reconciled to the triangle payment lags within an acceptable level.

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

- 113 medical claims processed by AGP,
- Ten NEMT claims processed by the subcontractor, Tennessee Carriers, Inc., and
- Ten vision claims processed by the subcontractor, Block Vision, Inc.

For one of the ten vision claims selected for testing, the claim did not represent a claim for TennCare services. The claim reported in the claims data file submitted to TDCI was actually for the Medicare plan offered by AGP. No explanation of the error has been provided. The accurate submission of data files for prompt pay testing is

critical in the determination of compliance with prompt pay requirements of Tenn. Code Ann. § 56-32-126(b)(1) and Section 2.22.4 of the CRA.

Management Comments

AGP concurs. AGP has worked with its subcontractor, Block Vision, Inc., to correct this matter and ensure future claims data file submissions will represent TennCare services only. This corrective action will be complete by AGP's submission of its September 2011 claims data file.

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. No discrepancies were noted in comparison of information submitted on claims to data in AGP's or subcontractor's claims processing system.

F. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing was to determine if claims selected were properly paid, denied, or rejected. For the 133 claims selected for testing, the following discrepancies related to adjudication accuracy were noted.

- For two of the 133 claims selected for testing, the claims were denied with the explanation "included in behavioral health case management rate and services paid via bi-weekly settlement." The status of both claims in prompt pay data files was also reported to TDCI as denied. 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.

  Management Comments

  AGP concurs. The original prompt pay file programming treated all case management rate codes that resulted in zero payment as a "denial" for prompt pay categorization purposes. When the manual case rate payment process began in September 2007, no modification of that programming occurred, so this issue has been in place since that time. By putting these claim records in the "capitated" category, they will not count at all in the prompt pay statistics. We are now correcting that categorization manually in the prompt pay data files until the production programming can be modified accordingly. AGP's correction was

implemented in the August 2011 prompt pay data file.

G. Price Accuracy Testing

The purpose of price accuracy testing was 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.

For the 133 claims selected for testing, no discrepancies were noted in testing of pricing accuracy.

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 top 100 enrollees by accumulated copayments for the period January 1, 2010 through December 31, 2010. From the listing, five enrollees were judgmentally selected for further testing of copayment application. For the five enrollees, all claims processed in calendar year 2010 were analyzed to determine if AGP had correctly applied copayment requirements of the CRA based upon the enrollee's eligibility status. The following discrepancies were noted:

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

  Management Comments

  AGP concurs. AGP is fixing the configuration errors that resulted in the incorrect application of member copayments. AGP will reprocess affected claims upon configuration completion. The target completion date for this corrective action is October 2011.

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.

No discrepancies were noted between the claims payment per the claims processing system and the related information communicated to the providers.

J. Analysis of Cancelled Checks

The purpose of analyzing cancelled checks 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.

The examiners requested AGP to provide five cancelled checks from claims tested. AGP provided the cancelled checks or the proof of electronic funds transfer. The check or paid amounts agreed with the amounts paid per the remittance advice 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 was 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 April 30, 2011, 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 211 claims exceeding 60 days in process. No material liability exists for claims over 60 days.

L. Electronic Claims Capability

Section 2.22.2.2 of the CRA states, “The CONTRACTOR shall have in place, an electronic claims management (ECM) capability that accepts and processes claims submitted electronically...” The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II (HIPAA) requires that all health plans be able to transmit and accept all electronic transactions in compliance with certain standards. Failure to comply with the standards defined for the transactions listed can result in the assessment of substantial penalties.

AGP accepts and processes claims submitted electronically. These claims can be rejected by AGP for accuracy and compliancy requirements. Rejected claims are returned with a rejection reason code transmitted to the provider’s electronic clearinghouse. TDCI and the TennCare Bureau reviewed the rejection code reasons in relation to the approval of AGP’s provider manual during the examination period. No discrepancies were noted.

M. Mailroom and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls was 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 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. TDCI interviewed the staff of the mailroom. Current mailroom processes were compared to the site visit results from the previous examination. AGP provided flowcharts documenting mailroom processes. Also, AGP provided testing results of AGP's internal audit of mailroom procedures.

The following is a summary of mailroom and claims inventory controls based upon the information provided by AGP. The mailroom for AGP operations is in Virginia Beach, Virginia. Medical claims should be submitted by providers to a specific mail box number. Each claim should be date stamped on the date of receipt. The date of receipt is stamped on the claim during the scanning process on the same date of actual mail receipt. If scanning isn't completed on the same day as claim receipt, scanning procedures require that the actual mailroom received date is utilized, not the date the claim is scanned. The scanned images are transferred to one of three vendors for data entry multiple times throughout the day. A claims rejection report tracks all claims rejected by the vendors during data entry. Reconciliations are performed every day to ensure that all claims received have been either loaded into the claims processing system or rejected and returned to provider. Additional reconciliations are performed to ensure completeness of claims submitted electronically or via website.

No additional test work of mailroom and inventory controls procedures was considered necessary by TDCI.

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 against AGP while a separate log tracks provider complaints received through AGP's claims processing department. TDCI judgmentally selected five provider complaints from the December 2010 TennCare Bureau provider complaint log and ten provider complaints from the December 2010 AGP claims processing department provider complaint log for testing. The following deficiencies were noted.

1. Provider Complaints Received via the TennCare Bureau

   Five complaints were selected for testing from the December 2010 log of provider complaints received via the TennCare Bureau. AGP did respond via the TennCare Bureau to providers within 30 days. 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 written correspondence that the provider agrees that resolution of the claim dispute will exceed 60 days per Tenn. 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).

Management Comments

AGP concurs. AGP's Bureau Service Desk (BSD) management process now includes provider notifications as required in Tenn. Code Ann. § 56-32-126(b)(2)(A). The BSD staff has been trained on the notification process and on the timely and accurate management of BSD issues to closure. Additional fields have been added to the BSD management tool, for improved dispute tracking and management. The provider notification process includes (1) sending an acknowledgement letter and/or a phone call to the provider informing them that we have received their dispute for our reconsideration of payment. The provider is notified that they will receive a written response from AGP within 30 days from the date AGP received their inquiry. (2) If their inquiry is not resolved within 30 days of receipt, AGP will notify the provider of the additional time required and will provide an estimated completion date. (3) In instances where the solution for corrected payment exceeds 60 days, AGP will obtain written documentation from the provider stating his/her agreement to the extended period of time required to receive accurate payment. In July 2011, processes were implemented and training completed to support items 1 and 2 above. By October 2011, processes will be implemented and training completed to support item 3 above.

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

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 agreement in writing for additional time with the provider. 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. 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).

- As previously mentioned, the CHOICES program for nursing facility and HCBS was implemented on March 1, 2010. The CRA requires AGP to establish systems which will allow enrollees to direct the scheduling of HCBS services. An enrollee's plan of care records the preferred scheduling which includes date and time specific visit preferences determined by the enrollee. The plan of care is maintained by AGP's care manager system which is separate from AGP's claims processing system. A subcontractor maintains an electronic visit verification system (EVV). The EVV authorizes AGP's providers to deliver HCBS services based upon the plan of care received from AGP's care manager system. The EVV telephonically verifies HCBS visits by providers. After the visit is confirmed, providers utilize the EVV to electronically submit claims to AGP for payment.

  As of field work in June 7, 2011, AGP had not required the subcontractor to enforce through the EVV 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.

  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.

  Management Comments

  AGP concurs. AGP has educated its staff and extension letters are being mailed to providers in the event a complaint cannot be resolved within thirty (30) days. In the event AGP is not able to resolve complaint within the sixty (60) day period, AGP will call the provider and agree on a

new target date. A copy of the e-mail and/or fax will be attached to the file. Training and process implementation for AGP's aforementioned corrective measures were completed in June 2011.

Additionally, AGP will not close a complaint dispute in the system until the claim has been adjusted. AGP will update the decision date to match the claim paid date. Education to process team owners was completed in August 2011.

AGP fully implemented EVV Member Preferred Scheduling in June 2011.

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, 2010, TDCI received and processed 62 provider complaints against AGP. The responses by AGP to providers were categorized by TDCI in the following manner:

Previous denial or payment upheld	22
Previous denial or underpayment reversed in favor of the provider	28
Previous denial or underpayment partially reversed in favor of the provider	2
Responses to issues other than claims payment	10

TDCI judgmentally selected 12 AGP provider complaints submitted to TDCI for review. The complaints were reviewed by analyzing issues raised by the provider. 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 noted in the review of provider complaints submitted to TDCI:

- For one of the twelve provider complaints selected for testing (Provider Complaint Number 2010-182), 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 (Provider Complaint Number 2010-314), 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.

  Management Comments

  AGP concurs with TDCI's finding with respect to claim issues related to Provider Complaint Number 2010-182. AGP educated its staff and the provider on AGP's authorization procedures on this provider's contract in March 2011.

  AGP concurs with TDCI's finding with respect to claim issues related to Provider Complaint Number 2010-314. The claim was selected for a prepayment audit. The claim was audited and released from the prepayment audit; however was not released for payment. In order to prevent this from occurring again, the prepayment Facets report will monitor the activity of claims that fall into the prepayment audit on a daily basis. Claims management has assigned a single point of contact to monitor this report, as well as developing an escalation process. In addition to the prepayment Facets report daily monitoring; the IT department will enhance their reconciliation reports for increased monitoring and controls. The aforementioned corrective measures were completed in July 2011.

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, 2010, 31 independent reviews were initiated by providers against AGP. The following is a summary of the reviewer decisions:

Reviewer decision in favor of the provider	9
AGP settled with provider upon submission of the independent review	10
Reviewer decision in favor of AGP	4
Reviewer decision in favor of AGP in part and provider in part	2
Review request submitted by provider was ineligible	6

TDCI judgmentally selected six independent reviews for testing. The independent reviews were analyzed for issues raised by the provider. 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 the resolution of independent reviews:

- For one of the six independent reviews selected for testing (Independent Review 10-091), 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 when the dispute was first submitted through AGP's provider complaint process.

  Management Comments

  AGP concurs. Denial of the provider complaint was due to associate oversight and education was provided to the associate in August 2011.

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 November 17, 2009, AGP submitted for prior approval an update to the provider manual related to the CHOICES program. The update was approved by TDCI on January 15, 2010. Additionally, on March 23, 2010, AGP submitted an update to the provider manual. The update was approved by TDCI on July 8, 2010.

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 medical 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 fifteen executed provider agreements were judgmentally selected for testing from the provider network directory files submitted by AGP directly to the TennCare Bureau. For one of the fifteen provider agreements selected for testing, the executed provider agreement 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.

Management Comments

AGP concurs. AGP's deficiency with respect to the one provider agreement selected for testing (not having been approved by TDCI) was as a result of a lack of sufficient controls during AGP's beginning stages of participation in the TennCare program. AGP currently has in place sufficient controls to prevent the release and execution of provider agreement templates prior to approval from TDCI. AGP will

submit any existing unapproved provider agreement templates to TDCI and targets review and approval completion by 4th Quarter 2011.

F. Provider Payments

Capitation payments to providers were tested during 2010 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.

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

- For four of the ten subcontracts selected for testing, the subcontracts were not submitted to TDCI or TennCare for prior approval.

- For one of the ten subcontracts selected for testing, an amendment to an 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 before execution.

Management Comments

AGP concurs. With respect to the subcontract submission process, AGP received approval on a model subcontractor addendum on June 16, 2011 as Matter 11-166. For subcontractors not previously submitted, AGP has been working with each vendor to review this addendum prior to submitting the existing contract documents for review. On a larger scale, AGP's Regulatory, Legal and Compliance Departments have also been working to introduce additional safeguards into the non-provider subcontract process to ensure that state filing is completed, as required. AGP's aforementioned corrective measures will be completed by December 2011.

For ACS, AIM, Connolly, and HMS, these contracts (with the exception of AIM) were in existence with the Corporation prior to the Tennessee implementation. We have

identified a process improvement moving forward that will better identify what contracts will be used for a new market through the implementation process to ensure that pre-existing contracts are submitted, as required. For Tennessee, though, we will submit these contracts to the Department as soon as possible for formal review and approval.

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 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. AGP provided its subcontractor review tools utilized to monitor subcontractor compliance. 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. Section 2.28.2 of the CRA states:

  > In order to demonstrate compliance with federal and state regulations of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) the CONTRACTOR shall designate a staff person to be responsible for non-discrimination compliance as required in Section 2.29.1. This person shall provide instruction to all CONTRACTOR staff, providers and direct service subcontractors regarding non-discrimination activities.

- 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 which states:

  > The CONTRACTOR warrants that no part of the total Agreement amount provided herein shall be paid directly, indirectly or through a parent organization, subsidiary or an affiliate organization to any state or federal officer or employee of the State of Tennessee or any immediate family member of a state or federal 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 the CONTRACTOR in connection with any work contemplated or performed relative to this Agreement unless disclosed to the Commissioner, Tennessee Department of Finance and Administration.

- AGP did not confirm that subcontractors submitted quarterly disclosures as 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.

  Management Comments

  AGP concurs. Monitoring efforts with respect to direct service subcontractors will be completed during 4th Quarter 2011. Such monitoring will include oversight of policies and procedures and regular reporting.

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.

However, Section 2.26.7 requires AGP to ensure that subcontractors comply with all applicable requirements of the CRA including non-discrimination requirements. As noted in Section VIII. H. of this report, AGP did not demonstrate monitoring or coordination efforts with direct service subcontractors related to non-discrimination requirements of Section 2.28.2 of the CRA.

Management Comments

AGP concurs. Monitoring efforts with respect to direct service subcontractors will be completed during 4th Quarter 2011. Such monitoring will include oversight of policies and procedures and regular reporting.

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 performed an internal audit of the TennCare plan. The audit report released August 10, 2010, included specific tests to determine compliance with the TennCare CRA requirements. AGP developed corrective action plans to each of the audit observations noted by Internal Audit. The audit observations were considered by TDCI during the current examination. TDCI was informed that internal audits of AGP will continue to be performed.

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 2011 for the calendar year 2010.

L. Contract to Audit Accounts

AGP is required to submit annual audited financial statements by May 1 for the preceding calendar year. Section 2.21.11.2 of the CRA requires such audits to be subject to prior approval of the Comptroller of the Treasury and to be submitted on the standard "Contract to Audit Accounts" agreement. The "Contract to Audit Accounts" between the Comptroller of the Treasury and the external auditor defines the standards for which the audits are to be performed. AGP has complied with this provision.

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.

However, Section 2.26.7 requires AGP to ensure that subcontractors comply with all applicable requirements of the CRA including conflict of interest requirements. As noted in Section VIII. H. of this report, AGP did not demonstrate monitoring efforts regarding the conflict of interest requirements in Sections 4.19 of the CRA.

Management Comments

AGP concurs. Monitoring efforts with respect to direct service subcontractors will be completed during 4th Quarter 2011. Such monitoring will include oversight of policies and procedures and regular reporting.

N. CHOICES

As previously mentioned, effective March 1, 2010, the CRA between AGP and the TennCare Bureau was amended for the implementation of the CHOICES program. CHOICES is TennCare's program for long-term care services. Long-term care services include care in a nursing home. Long-term care also includes certain services to help a person remain at home or in the community. Home and Community Based Services (HCBS) are services that include help doing everyday activities that enrollees may no longer be able to do for themselves as they grow older, or if they have a physical disability that prevents them from bathing, dressing, getting around their home, preparing meals, or doing household chores. Prior to implementation, AGP was required to contract with nursing facilities providing services for assigned enrollees. Additionally, AGP agreed to implement an electronic visit verification system (EVV) which telephonically verifies HCBS visits by providers. The following deficiencies were noted related to the CHOICES program administration:

- As previously noted in Section VII.C.1. AGP failed to meet 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 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 previously noted in Section VIII.A.2, as of field work in June 7, 2011, AGP has not required the subcontractor to enforce through the EVV 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.

Management Comments

AGP concurs. AGP has provided education to its associates, and automation of the patient liability calculation has been added to AGP's claims processing system. These measures will reduce the number of errors due to patient liability.

Furthermore, AGP has redefined its process for implementing rate changes to ensure compliance with Amendment 8 to the CRA, effective 7/1/2011. With this process change, AGP now completes appropriate configuration updates and reprocesses all impacted nursing facility claims, within 60 calendar days of receiving the rate change notification.

Additionally, AGP fully implemented EVV Member Preferred Scheduling in June 2011.

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.)

Complaint 2010-070 - On 2/2/10, a durable medical equipment (DME) provider sent a letter to AGP requesting a retroactive authorization. Provider complained about the inability to check on status of claims and requests for retroactive authorization. Provider alleged AGP said there was not a phone number to call to check on the status of claims or retro authorizations.

- AGP's Response: Provider's issue regarding prior authorization for DME during ER visit. AGP account representative spoke to provider (3/11/2010), and advised provider to file the claims along with the medical records to request retroactive authorization. Also, AGP provider representative confirmed with provider that provider now has an understanding of AGP's claim and dispute process.

    - TDCI's Follow up Questions: Does AGP have a record of the provider's 2/2/10 request letter? If so, what was AGP's response?

- AGP's Comments/Follow up: We received provider's letter dated 2/2/10 on 2/8/10. There was no claim on file for the services that was being disputed. Retro authorization request has never been reviewed in coordination with the claim received from provider. Provider relations representative called provider and educated in the provider dispute process.

Complaint 2010-100 – Provider complained that AGP denied a claim with dates of service 8/12/09-8/28/09 for no authorization and/or no out-of-network benefits. This DME provider was not in AGP's provider network.

- AGP's Response: AGP's response letter stated that AGP understands that the provider had spoken to AGP provider service representative. AGP provider representative reported that the Member was placed on the monitor by an AGP participating provider. As such, an exception memo has been completed to override the authorization requirements and to subsequently pay this claim.

    - TDCI's Follow up Questions: Was this improperly denied? Provider's request was noted as a second level appeal. Did AGP receive an initial complaint letter?

- AGP's Comments/Follow up: Two claims both denied on 9/12/09 for no authorization. Claim was denied properly, authorization is required for this service. We received provider's initial

payment dispute/appeal on 10/6/09 and denial was upheld. Per AGP policy authorization must be obtained prior to services rendered. No authorization on file, no evidence of attempt made to obtain prior authorization. Claims later reprocessed when authorization exception memo was provided by provider relations representative in a good faith gesture based on the fact that the service was ordered by a par provider and there are no providers who have that equipment in the area that are par with AGP.

Complaint 2010-130 - Provider complained that AGP denied a claim with a date of service 5/31/09 due to improper coding issues and no prior authorization.

- AGP's Response: AGP letter dated 3/17/10 stated that payment is not appropriate for the services rendered. Also, AGP's claim auditing software indicated CPT code 52352-51 is incidental to code 52344-59. However, this 3/17/10 letter does not mention no authorization. After the complaint was filed, AGP letter dated 4/29/10, states that this claim reprocessed and no authorization is required for 23-hour observation.

  - TDCI's Follow up Questions: What were the denial codes on the EOB? Based on the provider's comments, why did the AGP representative state that an authorization was required and in the 4/29/10, letter AGP stated that an authorization was not required? Has AGP modified AGP's claims auditing software or developed a process to mitigate this?

- AGP's Comments/Follow up: The denial code on the EOP was no authorization. We have a global exception memo in place for the analyst to manually override the authorization requirements until the system is configured to not require an authorization for these types of services.

Complaint 2010-182 – On 5/18/10, provider complained that AGP incorrectly denied a claim with the explanation service is not allowed under contract. On 6/14/10, AGP responded to TDCI and the provider that the denial will be reversed.

- AGP's Response: It is my understanding that AMERIGROUP Provider Relations Representative spoke to a representative with the provider and explained that the claim in question is being reprocessed for payment per the contract. AGP will follow-up with this representative as soon as the claim processes to provide the paid amount.

  - TDCI's Follow up Question: Claim was not reversed as of field work. Why was it denied as not allowed under the contract?

- AGP's Comments/Follow up: Claim originally denied as not covered under contract. The provider dispute was upheld as per our interpretation of the contract. The account

representative for this national account responded with the below information and that is why the claim was adjusted.

> "Please process the claim according to my instructions. As the negotiator for the DME provider National Contract, the intent of the contract is to reimburse up to the CMS purchase price. Since this is a "capped rental", you have to calculate the payment as it is not on the fee schedule, since this service was authorized. The provider is a National DME Contract that is reimbursed off the CMS DMEPOS fee schedule. CMS categorized this service as a "capped rental", which means that it is a rental only item. CMS prices this code as a "capped rental" at the appropriate rate. CMS allows up to 13 months of the rental price to equate to the purchase price of an item. CMS does not put the purchase price (NU) on the fee schedule because it is deemed a "capped rental" and on rare occasion, CMS may pay for a purchase, and will calculate the payment accordingly. Our UM authorized the purchase instead of a rental. Our PR lead in TN and myself will team together to create a job aid for the HP UM team to help them understand the process and reimbursement. Based on the intent of the contract, we would reimburse up to the CMS purchase price of the item (which is the rental x 13 months) x 75% (contract percentage). I apologize, I misread the contract percentage. The percentage should be 75%, not 65%. The provider also has a default pricing using the AGP GAP Fee Schedule that is loaded behind the scenes. The provider does not have to send in a corrected claim, as this is a covered service, authorized for purchase using the formula provided."

Complaint 2010-257 – A provider complained that AGP incorrectly denied several claims with the explanations "total minutes of reportable anesthesia time in field 19" and "minutes needed, resubmit with start/stop time."

- AGP's Response: AGP has reviewed the claim in question and reprocessed the claim for payment on July 2, 2010.

  - TDCI's Follow up Question: What process did AGP use in determining that a denial was proper?

- AGP's Comments/Follow up: Claim denied correctly. The units are not identified as minutes and the start and stop time are difficult to read. This issue will continue to occur if the provider doesn't submit clear images. I reviewed recent submission and the claims submitted by the provider are legible.

Complaint 2010-270 - A provider complained that AGP incorrectly denied a claim because of the improper use of Modifier 50.

- AGP's Response: AMERIGROUP has reviewed the claim identified in this complaint and has reprocessed the claim to pay the approved 80% of total billed charges as identified on the single case agreement. The reimbursement should be disbursed by August 10, 2010.

    - TDCI's Follow up Question: Are there other providers that used Modifier 50 and have been denied?

- AGP's Comments/Follow up: This claim was denied in error. System was configured at a later date to allow procedure combination. There are 2 claims that were denied in error and will be adjusted on 5/26/11.

Complaint 2010-274 - A provider complained that AGP incorrectly denied services for a claim with the diagnosis code 632.

- AGP's Response: AGP noted that it is continuing to have issues with reprocessing this claim based on the code used to bill the service in question and has put a manual override in place to pay the claim as submitted.

    - TDCI's Follow up Questions: How was this resolved? Was the code the provider used proper?

- AGP's Comments/Follow up: AGP updated configuration in system to allow for payment on diagnosis code 632 and claim was reprocessed. Coding by provider was correct.

Complaint 2010-277 - A provider complained that AGP incorrectly denied one procedure billed on a claim. Provider resubmitted the claim for reprocessing and several attempts were made by provider to resolve the issue.

- AGP's Response: AGP responded that the provider was contacted about AGP's decision to overturn its previous appeal decision and reprocess the claim for payment. The claim paid $254.18 on July 24, 2010.

    - TDCI's Follow up Questions: Why did AGP reverse its previous appeal? Since several attempts were made by the provider, did AGP determine that additional training for the provider representatives was necessary?

- AGP's Comments/Follow up: Provider submitted payment dispute on 6/28/2010 that was overturned on 7/15/2010 for payment. In order to process the claim the provider had to submit a corrected claim. Which they did with the dispute.

Complaint 2010-301 - Provider noted they were originally overpaid for services and the provider returned the overpayment to AGP. However, AGP incorrectly began to deduct the entire amount from new invoices.

- AGP's Response: The three claims in question were recouped because the contract-required modifier was not present on the submitted claims. As claims were not resubmitted with the correct modifier, the full payment amounts for these claims were submitted for recoupment. The total recoupment amount is $324.89 of which AGP received payments totaling $119.22.

    - TDCI's Follow up Question: Why was this denied?

- AGP's Comments/Follow up: Per Providers contract, services rendered by Licensed Master's Clinician must be billed with an HO modifier. Claims were not billed with this modifier; AGP received other claims in same time frame billed with modifier that paid.

Complaint 2010-314 - A provider complained that AGP incorrectly denied a claim with the explanation "lack of medical records".

- AGP's Response: AGP reprocessed and paid the claim on 8/25/10. (TDCI notes that the actual paid date per the claim processing system is 8/26/10.)

    - TDCI's Follow up Question: Why was this denied?

- AGP's Comments/Follow up: Dispute received in April and overturned but we needed itemized bill. Provider submitted itemized bill on 7/16 and dispute on 7/19. Dispute was overturned and claim adjusted on 7/29. This case was not adjusted due to a state complaint.

Complaint 2010-315 - A provider complained that AGP has denied a claim with the explanation "lack of medical records".

- AGP's Response: AGP agreed to reprocess and pay the claim.

    - TDCI's Follow up Question: Why was this denied?

- AGP's Comments/Follow up: The provider submitted 5 multiple claims for the DOS in question. Claims continued to deny for medical records because the member was retro enrolled. Provider submitted dispute and we requested additional documentation that was never received. The provider submitted a second level dispute after the appeal benefits were exhausted. Health plan reviewed medical records and authorization was approved. Payment was made on claim.

Complaint 2010-358 - A provider complained that AGP incorrectly denied a claim with the explanation that the services are non-covered.

- AGP's Response: AGP cited delays in the execution of an amendment which became effective March 1, 2010. AGP sent this Amendment via certified mail and confirmation was returned to sender. Claims from March 1, 2010 that have been billed for services covered by this Amendment will be reprocessed. The claim referenced in this complaint is currently being reprocessed in accordance with the Amendment.

  - TDCI's Follow up Question: Why was this denied?

- AGP's Comments/Follow up: Claim originally denied as contract amendment allowing payment of these services had not been configured.

Appendix 2

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

IR 10-025 - Issue and Independent Review (IR) Decision: A provider submitted an IR which alleged AGP incorrectly denied a claim with the explanation "Payment not appropriate for the services rendered." AGP reversed its previous denial before the independent reviewer's decision was rendered.

- TDCI's Follow up Question: Why was this denied?

o AGP's Response: Claim denied due to N59 incidental due to a procedure in history. During dispute, nurse reviewed and agreed with denial as per CMS guidelines. When the IR was received the health plan's medical director reviewed the medical records and approved payment. Medical directors use their experience and medical training to make such decisions. [This] doesn't always link up with CMS billing guidelines.

IR 10-047 - Issue and IR Decision: A provider submitted an IR which alleged AGP incorrectly denied claims for various reasons and the MCO failed to pay based on a new agreement. The Independent Reviewer issued a decision in favor of the provider.

- TDCI's Follow up Question: Why was this denied?

o AGP's Response: AGP didn't agree with the IR being overturned to the provider. There were a total of 214 claims in the spreadsheet. They originally denied for timely filing correctly. Claims were adjusted accordingly as per the independent reviewer's decision.

IR 10-062 - Issue and IR Decision: A provider submitted an IR which alleged AGP incorrectly denied claims as not medically necessary. AGP reversed its previous denial before the independent reviewer's decision was rendered.

- TDCI's Follow up Question: Why was this denied?

o AGP's Response: Claim denied code J9310 and J2469 for no authorization correctly. Provider submitted additional information with their IR request and that is why the authorization was approved after further review.

IR 10-079 - Issue and IR Decision: A provider submitted an IR which alleged AGP incorrectly recouped previous payments. AGP alleged that the services were not payable since they were covered under a global maternity payment. AGP reversed its previous denial before the independent reviewer's decision was rendered.

- TDCI's Follow up Question: Why was this denied?

o AGP's Response: Claim money was recouped on Claim due to the following reason: "When billing a global maternity code (59400, 59510, 59610, 59618) CPT states these codes includes monthly evaluation and management services until delivery and postpartum care including hospital visits and office visits following delivery. Forager Project #354 Working project TN-2009-0189 Adjust Eligible Report- retracting $145.81". After further review it was determined that services were not related to global maternity care and claim was adjusted. Claim was recouped incorrectly and this should have been caught on the dispute. That is why we made payment through the IR.

IR 10-091 - Issue and IR Decision: A provider submitted an IR 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. AGP reversed its previous denial before the independent reviewer's decision was rendered.

- TDCI's Follow up Question: Why was this denied?

o AGP's Response: Claim was received on 12/10 and processed on 12/12. Code 96375 MOD 59 denied correctly as add-on code missing because the add-on code was billed on a different claim and that claim was received and processed on 12/14. This is a timing issue on the provider's billing practice and it would affect any other provider that doesn't bill the add-on code together. The dispute from the provider was not handled correctly and it should have been overturned.

IR 10-094 - Issue and IR Decision: A provider submitted an IR which alleged AGP incorrectly denied for lack of modifier billed with a specific procedural code. AGP reversed its previous denial before the independent reviewer's decision was rendered.

- TDCI's Follow up Question: Why was this denied?

o AGP's Response: Claim denied code 96366 as missing add on code. According to the CPT manual "Report 96365 for the initial hour and 96366 for each additional hour. Report 96367 for each additional sequential infusion, up to one hour, and 96368 for each concurrent infusion of substances." Later there was a correction that "chemotherapy or other highly complex drugs or biologic agents" can be the initial infusion for the first hour (96413, 96415). The provider billed 96413 and 96415 in conjunction with 96366 on the claim. The system was corrected and claim was reprocessed.

- TDCI Follow up Question: When was the system corrected?

- AGP Comments/Follow ups: This was a claim check update ACCR submitted 3/5/10 and completed 4/11/10 FCC#350. The system was updated after the claim was processed the first time. Dispute was upheld correctly because the system was not corrected. This was corrected in the system when the IR was received. Copy of our IR response was provided to auditor.