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, 2016
THROUGH DECEMBER 31, 2016

TABLE OF CONTENTS

I. FOREWORD

II. PURPOSE AND SCOPE

III. PROFILE

IV. SUMMARY OF CURRENT FINDINGS

V. DETAIL OF TESTS CONDUCTED - FINANCIAL ANALYSIS

VI. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING

VII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

Appendix – Previous Examination Findings

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DATE:	September 19, 2017

The Financial and Compliance Examination and Market Conduct Examination of the TennCare Operations of AMERIGROUP Tennessee Inc., Nashville, Tennessee, was completed June 22, 2017. The report of this examination is herein respectfully submitted.

I. FOREWORD

On March 23, 2017, the TennCare Oversight Division of the Tennessee Department of Commerce and Insurance (TDCI) notified representatives of AMERIGROUP Tennessee, Inc., (AGP) of its intention to perform a Financial and Compliance Examination and Market Conduct Examination of AGP's TennCare Operations. Fieldwork began on June 12, 2017, and ended on June 22, 2017. All document requests were provided by July 13, 2017.

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

II. PURPOSE AND SCOPE

A. Authority

This examination of AGP's TennCare operations was conducted jointly by TDCI and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller), under the authority of Section A.2.25 of the Contractor Risk Agreement for Tennessee (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, 2016.

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

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

C. Purpose and Objective

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

The objectives of the examination were to:

- Determine whether AGP met certain contractual obligations under the CRA and whether AGP was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-101 *et seq*.;

- Determine whether AGP had sufficient financial capital and surplus to ensure the uninterrupted delivery of health care services for its TennCare members on an ongoing basis;

- Determine whether AGP's TennCare operations properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether AGP's TennCare operations had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and

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

III. PROFILE

A. Administrative Organization

AGP was incorporated under the laws of the State of Tennessee on April 26, 2006. AGP was licensed as an HMO by TDCI on March 29, 2007, for the purpose of participating as an MCO in the TennCare program. AGP is a wholly-owned subsidiary of AMERIGROUP Corporation, which in turn is a wholly owned subsidiary of Anthem, Inc. Anthem, Inc. is a publicly held company trading on the New York Stock Exchange.

The officers and directors or trustees for AGP as reported on the NAIC Annual Statement for the year ending December 31, 2016, were as follows:

Officers for AGP

Charles Brian Shipp, Chairperson
Alvin Brock King, President/CEO
Edna Laverne Willingham, Vice President/COO
Jack Louis Young, Vice President/Asst. Secretary

Other Officers for AGP

Kathleen Susan Kiefer, Secretary
Kendall Benjamin Edwards, Vice President, Finance
Robert David Kretschmer, Treasurer
Mark Daniel Justus, Valuation Actuary
Eric (Rick) Kenneth Noble, Vice President/Asst. Treasurer

Directors or Trustees for AGP

Carter Allen Beck
Charles Brian Shipp
Alvin Brock King
Catherine Irene Kelaghan

B. Brief Overview

For the Middle Tennessee Grand Region effective April 1, 2007, the East Tennessee Grand Region and the West Tennessee Grand Region effective January 1, 2015, AGP is contracted through an at-risk agreement with the TennCare Bureau to received monthly capitation payments based on the number of enrollees assigned to AGP and each enrollee’s eligibility classification.

As of December 31, 2016, AGP had approximately 440,000 TennCare members state-wide. The TennCare benefits required to be provided by AGP are:

- Medical
- Behavioral health
- Vision
- Long-term services and supports (“CHOICES” program)
- Employment and Community First (“CHOICES” program)
- Non-emergency transportation services

Effective July 1, 2016, AGP began offering services through the Employment and Community First CHOICES program. Employment and Community First CHOICES is a new program for people of all ages who have an intellectual or developmental disability (I/DD). Services in the new program will help people with I/DD live as independently as possible at home or in the community, not in an institution. If the person lives at home with their family, the services help their family support them to become as independent as possible, work, and actively participate in their communities. Benefits include self-advocacy supports for the person and for their family. Residential services are also covered for adults who need them. For the year ending December 31, 2016, AGP had 225 enrollees in the Employment and Community First CHOICES program.

In addition to TennCare operations, AGP began offering a Medicare Advantage Special Needs Plan for those who are eligible for both Medicaid and Medicare in January 2008. Also effective January 2011, AGP received approval from the Centers for Medicare and Medicaid Services to cover traditional Medicare beneficiaries in addition to the existing special needs beneficiaries. For the year ending December 31, 2016, AGP had approximately 9,500 Medicare enrollees in Tennessee.

C. Claims Processing Not Performed by AGP

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

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

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

IV. SUMMARY OF CURRENT FINDINGS

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

A. Financial Deficiencies

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

B. Claims Processing Deficiencies

1. Prompt pay testing by TDCI determined that the vision subcontractor, Superior Vision, Inc., did not process claims in compliance with Section A.2.22.4 of the CRA for the months of August, September, October, November and December 2016. The failure to achieve prompt pay compliance continued for the months of January, February and March 2017.

   (See Section VI.A. of this report)

2. Prompt pay testing by TDCI determined that CHOICES claims were not processed in compliance with Section A.2.22.4 of the CRA for the months of January, February and May 2016.

   (See Section VI.A. of this report)

3. AGP failed to achieve claims payment accuracy requirements of 97% per Section A.2.22.6 of the CRA for Nursing Facilities claims in the East Region for the month of September 2016. Also, AGP failed to achieve claims payment accuracy requirements for home and community-based services (HCBS) in the East, Middle and West Regions for the month of November 2016.

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

4. The CRA requires AGP to self-test the accuracy of claims processing based on claims selected by TDCI on a monthly basis. For the 900 claims tested for calendar year 2016, AGP reported at least one attribute error on 155 claims during focused claims testing.

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

5. During the review of focused claims testing results, TDCI noted the following additional deficiencies:

   - For the January 2016 focused claims testing, AGP indicated three claims were incorrectly denied with reason code “UM1 – units exceed UM authorization.” AGP’s claims processing system was incorrectly applying four units against the authorization for each unit of service paid which prematurely exhausted the available authorized units.

     (See Section VI.D.2.a.1. of this report)

   - For the February 2016 focused claims testing, AGP indicated four claims were incorrectly denied with reason code “G72 – No MCD#/Disclosure

Form". AGP stated the disclosure form was received August 13, 2015, but the form was not properly loaded in the claims processing system.

(See Section VI.D.2.a.2. of this report)

- For the April 2016 focused claims testing, AGP indicated that capitated service lines were incorrectly reported with a denied status on the monthly prompt pay file submission to TDCI.

  (See Section VI.D.2.a.3. of this report)

- In the March 2016 focused claims testing, TDCI discovered that for multiple claims submitted by the vision subcontractor, not all service lines were reported to TennCare as encounter data.

  (See Section VI.D.2.b. of this report)

- In the April 2016 focused claims testing, TDCI noted there were two claims that took longer than 60 days for AGP to process. The claims were improperly considered by AGP as corrected claims versus claims appeals. Since these claims were not properly identified as claims appeals, the considerable processing delay violated Tenn. Code Ann. § 56-32-126(b)(2)(A).

  (See Section VI.D.2.c. of this report)

- For the November and December 2016 focused claims testing, AGP indicated that one claim was incorrectly denied as a result of a system error with the reason code "G43 - PV Coded billed with wrong Type of Bill". AGP had implemented a system configuration change which caused the error.

  (See Section VI.D.2.d. of this report)

6. TDCI reviewed 48 claims reported by AGP as being processed correctly during focused claims testing for the calendar year 2016. TDCI noted one of the 48 claims was denied with the denial reason code "pre-auth not obtained". Despite having an authorization in the system at the time of service, this Electronic Visit Verification system (EVV) claim denied incorrectly for "pre-auth not obtained". On the date of service, an authorization had been granted and the provider performed the agreed to service.

   (See Section VI.D.3.a. of this report)

7. TDCI reviewed 54 claims reported by AGP as being processed incorrectly during focused claims testing for the calendar year 2016. TDCI noted that two of the 54

claims that AGP reported as inaccurately processed were not corrected by AGP as of fieldwork during June 2017.

(See Section VI.D.3.a. of this report)

8. For two of five enrollees selected for copayment testing, errors were discovered in the application of copayments. AGP incorrectly applied the required copayment to the enrollee's claim based upon the enrollee’s eligibility status.

   (See Section VI.E. of this report)

C. Compliance Deficiencies

1. For the test month of December 2016, the following deficiencies were noted in review of AGP’s claim processing provider complaint log:

   - Nine of the 25 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.

   - Five of the 25 provider complaints selected for testing were not resolved within 60 days and no written agreement with the provider was executed to allow for additional time to resolve the complaint.

     (See Section VII.A. of this report)

2. Six of the twenty-seven executed provider agreements provided and tested were not on templates that were approved by TDCI on February 8, 2016. The provider agreements did not contain the most current TennCare regulatory appendix and regulatory language that incorporates CRA amendments 4 and 5.

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

3. The following deficiencies were noted during the testing of subcontracts:

   - Two of the five executed subcontracts selected for testing have never been submitted to TDCI and the TennCare Bureau for prior approval.

   - For one of the five subcontracts selected for testing, Amerigroup determined that filing the subcontract with the TDCI and the TennCare Bureau was not necessary. The subcontract should have been prior approved by the TennCare Bureau and TDCI.

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

4. The following was noted during the review of AGP's compliance with the Health Insurance Portability and Accountability Act (HIPAA):

   In February 2015, Anthem reported that it was the target of a sophisticated external cyber-attack. The attackers gained unauthorized access to certain of Anthem's information technology systems and obtained personal information related to many of Anthem's current and former members and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses and employment information, including income data. AGP estimates that more than 246,000 current or former AGP TennCare enrollees may have been impacted by the data breach discovered on January 29, 2015.

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

5. During the testing of episodes of care reports for calendar year 2016, TDCI noted an error in the improper identification and application of a risk marker for an enrollee. The provider report indicated risk adjusted cost for this enrollee of $10,528 which is understated by $547.14 or 5.2%.

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

V. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, AGP is required to file annual and quarterly NAIC financial statements in accordance with NAIC guidelines with 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, 2016, AGP reported $531,920,598 in admitted assets, $353,724,073 in liabilities and $178,196,525 in capital and surplus on the 2016 Annual Statement submitted March 1, 2017. AGP reported total net income of $13,377,229 on the statement of revenue and expenses. The 2016 Annual Statement and other financial reports submitted by AGP can be found at https://www.tn.gov/commerce/article/tncoversight-managed-care-organization-financial-reports.

1. Capital and Surplus

   a. Risk-Based Capital Requirements:

      AGP is required to comply with risk-based capital requirements for health organizations as codified in TCA § 56-46-201 et seq. AGP has submitted a report of risk-based capital (RBC) levels as of December 31, 2016. The report calculates an estimated level of capital needs for financial stability depending upon the health entity's risk profile based on instructions adopted by the NAIC. As of December 31, 2016, AGP maintains an excess of capital over the amount produced by the Company Action Level Events calculations required by TCA § 56-46-203. Additionally, AGP's RBC report did not trigger a trend test as determined with trend test calculations included in the NAIC Health RBC instructions. The following table compares reported capital and surplus to the Company Action Level requirements as of December 31, 2016:

Reported Capital and Surplus	$178,196,525
Reported Authorized Control Level Risk-Based Capital	$61,438,908
Computed and Required Company Action Level Risk-Based Capital (200% of Authorized Control Level)	$122,877,816

   b. HMO Net Worth Requirement:

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

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

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

To determine the minimum net worth requirement as of December 31, 2016, 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, 2016, or (2) the total cash payments made to AGP by the TennCare Bureau plus premium revenue earned from non-TennCare operations for the period ending December 31, 2016.

(1) For the period ending December 31, 2016, AGP reported total company premium revenues of $1,968,923,691 on the 2016 NAIC Annual Statement.

(2) For the period ending December 31, 2016, AGP reported total payments from the TennCare Bureau of $ 1,866,304,392 and premium revenue from non-TennCare operations of $111,746,180 for a total of $1,978,050,572.

Utilizing $1,978,050,572 as the premium revenue base, AGP's minimum net worth requirement as of December 31, 2016 is $33,420,759 ($150,000,000 x 4% + ($1,978,050,572 -150,000,000) x 1.5%). AGP's reported net worth at December 31, 2016, was $144,775,766 in excess of the required minimum.

2. <u>Restricted Deposit</u>

TCA § 56-32-112(b) sets forth the requirements for AGP's restricted deposit. AGP's restricted deposit agreement and safekeeping receipts currently meet the requirements of TCA § 56-32-112(b). Utilizing $1,978,050,572 as the premium revenue base, AGP's restricted deposit requirement as of December 31, 2016 is $11,100,000. As of December 31, 2016, AGP had on file with TDCI, a depository agreement and properly pledged safekeeping receipts totaling $17,366,000 to satisfy restricted deposit requirements.

3. <u>Claims Payable</u>

AGP reported $190,512,231 claims unpaid as of December 31, 2016. Of the total claims unpaid reported, $179,404,419 represented the claims unpaid for TennCare operations. The reported amount was certified by a statement of actuarial opinion.

Analysis by TDCI of medical payments from January 1, 2017 through June 30, 2017 for dates of services before January 1, 2017 and review of subsequent

NAIC financial filings determined that the reported claims payable for TennCare operations was adequate.

B. TennCare Operating Statement

Sections A.2.30.16.3.3 and A.2.30.16.3.4 of the CRA require each submission of NAIC financial statements to contain a separate income statement detailing the quarterly and year-to-date revenues earned and expenses incurred as a result of participation in the TennCare program. For the year ended December 31, 2016, AGP's TennCare Operating Statement reported Total Revenues of $1,802,937,083, Medical Expenses of $1,513,512,500, Administrative Expenses of $282,186,304, Income Tax Expense of $2,521,043 and Net Income of $4,717,236.

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

C. Medical Loss Ratio Report

Section A.2.30.16.2.1 of the CRA requires:

> The CONTRACTOR shall submit a Medical Loss Ratio Report monthly with cumulative year to date calculation. The CONTRACTOR shall report all medical expenses, including for ECF CHOICES, costs related to the provision of support coordination, and complete the supporting claims lag tables. This report shall be accompanied by a letter from an actuary, who may be an employee of the CONTRACTOR, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy. The CONTRACTOR shall also file this report with its NAIC filings due in March and August of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report shall reconcile to NAIC filings including the supplemental TennCare income statement. The CONTRACTOR shall also reconcile the amount paid reported on the supporting claims lag tables to the amount paid for the corresponding period as reported on the CONTRACTOR's encounter file submission as specified in Sections A.2.30.18.3 and A.2.23.4.

AGP submits medical loss ratio (MLR) reports for each region on the basis of the State's fiscal year which ends on June 30. The medical loss ratio percentage is based upon total medical payments plus incurred but not reported (IBNR) claims estimate divided by capitation revenue net of premium tax. TDCI performs an analysis of each region and for all regions combined. AGP's MLRs for the period July 1, 2016, through December 31, 2016, were submitted January 23, 2017. Based on TDCI's analysis, the combined medical loss ratio with capitation revenue net of

premium tax was 84.83% for this period. AGP's June 2017 MLRs were submitted on July 21, 2017. Based on an analysis of AGP's June 2017 MLRs for the period July 1, 2016 through December 31, 2016, the combined medical loss ratio was 83.96%. The reason for the decrease in the MLR percentage was due to adjustments of 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 reportable discrepancies were noted during the review of documentation supporting the amounts reported on the MLR reports.

D. Administrative Expenses and Management Agreement

For the year ended December 31, 2016, AGP reported total Administrative Expenses of $294,269,089 which included direct expenses incurred by AGP and administrative and support services fees paid pursuant to the management agreement between AGP and Anthem, Inc. Administrative Expenses represented approximately 15.0% of total premium revenue.

Effective January 1, 2014, the company entered into an administrative services agreement with its affiliated companies which the Department approved on February 20, 2014. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The costs and expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Direct costs include expenses such as salaries, employee benefits, communications, advertising, consulting services, maintenance, rent utilities, and supplies which are directly attributable to the Company's operations. Allocated costs include expenses such as salaries, benefit claims and enrollment processing, billings, accounting, underwriting, product development and budgeting, which support the Company's operations. These costs are allocated based on various utilization statistics.

The fee paid to Anthem, Inc. for administrative services is based on a management agreement previously approved by TDCI. The fees paid to Anthem, Inc. are based upon a cost allocation method consistent with NAIC Statement of Statutory Accounting Principles (SSAP) No. 70.

SSAP 70 recognizes that an entity may operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, shall be apportioned to the entities incurring the expense as if the expense had been paid solely by the incurring entity. The apportionment shall be completed based upon specific identification to the entity incurring the expense. Where specific identification is not feasible apportionment shall be based upon pertinent factors or ratios.

For the year ended December 31, 2016, management fees/allocated expenses of $178,001,784 were charged to AGP by Anthem Inc. The management fee represented approximately 9.0% of total premium revenue.

The allocation methodologies utilized by AGP were reviewed by TDCI. No reportable items were noted during the review of allocation methodologies.

E. Schedule of Examination Adjustments to Capital and Surplus

No adjustments are recommended to Capital and Surplus for the period ending December 31, 2016, as a result of the examination of AGP's TennCare operations.

VI. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

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

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.
>
> > (A) "Pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.
> >
> > (B) "Process" means the health maintenance organization must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either that the claim had been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate

written or electronic notice must specifically identify all such information and documentation.

TDCI currently determines compliance with Tenn. Code Ann. § 56-32-126(b)(1) by testing monthly data file submissions from each of the TennCare MCOs. Each month is tested in its entirety for compliance with the prompt pay requirement of the statute. If a TennCare MCO fails to meet the prompt pay standards for any subsequent month after the month in which non-compliance was communicated by TDCI, the MCO will be penalized as allowed by the statute in an amount not to exceed ten thousand dollars ($10,000). The TennCare MCO is required to maintain compliance with prompt pay standards for twelve months after the month of failure to avoid the penalty.

Prompt Pay Results for All Claims Processed

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

AGP All TennCare Operations	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2016	98%	99.8%	**Yes**
February 2016	99%	99.9%	**Yes**
March 2016	99%	99.9%	**Yes**
April 2016	100%	99.9%	**Yes**
May 2016	100%	100.0%	**Yes**
June 2016	100%	100.0%	**Yes**
July 2016	100%	100.0%	**Yes**
August 2016	100%	99.9%	**Yes**
September 2016	99%	99.8%	**Yes**
October 2016	100%	99.9%	**Yes**
November 2016	99%	99.9%	**Yes**
December 2016	100%	99.9%	**Yes**

When combining the results for all claims processed, AGP was in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for all months in 2016.

Prompt Pay Results for Vision

The following table represents the results of prompt pay testing for all TennCare claims processed by Superior Vision, Inc.

Vision Claims	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2016	100%	100.0%	**Yes**
February 2016	100%	100.0%	**Yes**
March 2016	100%	100.0%	**Yes**
April 2016	100%	100.0%	**Yes**
May 2016	100%	100.0%	**Yes**
June 2016	99%	100.0%	**Yes**
July 2016	91%	100.0%	**Yes**
August 2016	93%	98.4%	**No**
September 2016	85%	94.3%	**No**
October 2016	96%	97.9%	**No**
November 2016	96%	98.6%	**No**
December 2016	96%	98.2%	**No**

Prompt pay testing by TDCI determined that the vision claims subcontractor, Superior Vision, Inc. did not process claims in compliance with Section A.2.22.4 of the CRA for the months of August, September, October, November and December 2016. The failure to achieve prompt pay compliance continued for the months of January, February and March 2017.

AGP and Superior Vision, Inc. submitted a corrective action plan for non-compliance with the prompt pay requirements for the month of August 2016 to TDCI. The corrective action plan included specific actions to achieve prompt pay compliance:

- Superior Vision performed a quality assurance check on 100% of all claims that are adjudicated out of its enhanced IT system at the end of September 2016. In October 2016, Superior Vision reverted back to performing quality assurance checks on a random sampling of claims.

- Superior Vision started performing check runs on a weekly basis. This will assist Superior Vision in meeting its goal to meet and exceed the State of Tennessee's prompt pay requirements.

- Superior Vision's Claims Department began running bi-weekly claims aging detail reports in order to verify that it will pay Amerigroup Tennessee claims within 60 days.

The corrective actions taken were not successful. TDCI requested and received updated monthly corrective action plans until Superior Vision, Inc. achieved compliance in April 2017. AGP stated during examination fieldwork that the contract with Superior Vision, Inc. had been terminated. AGP is in the process of contracting with a new vision subcontractor.

<u>Management Comments</u>
AGP concurs. AGP will be terminating the services contract of Superior Vision, Inc. effective on/or before December 31, 2017.

Prompt Pay Results for NEMT Claims

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

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

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

Prompt pay testing by TDCI determined that the NEMT subcontractor, Tennessee Carriers, Inc. processed claims in compliance with Sections A.15.3 and A.15.4 of ATTACHMENT XI of the CRA for all months in calendar year 2016.

Prompt Pay Results for CHOICES Claims

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

- Ninety percent (90%) of clean claims for nursing facility services and CHOICES HCBS 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 CHOICES HCBS I shall be processed and paid within twenty-one (21) calendar days of receipt.

Prompt pay testing by TDCI determined that nursing facility and CHOICES HCBS claims were processed as reported in the following table:

CHOICES	Clean claims Within 14 days	All claims Within 21 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2016	85%	99.9%	**NO**
February 2016	68%	97.4%	**NO**
March 2016	98%	99.8%	**Yes**
April 2016	100%	99.9%	**Yes**
May 2016	99%	99.4%	**NO**
June 2016	99%	99.9%	**Yes**
July 2016	99%	100.0%	**Yes**
August 2016	99%	100.0%	**Yes**
September 2016	100%	99.9%	**Yes**
October 2016	99%	99.7%	**Yes**
November 2016	100%	100.0%	**Yes**
December 2016	100%	99.9%	**Yes**

Prompt pay testing determined that nursing facility and CHOICES HCBS claims were not processed in compliance with Section A.2.22.4 of the CRA for the months of January, February and May 2016.

AGP submitted to TDCI a corrective action plan for non-compliance with Section A.2.22.4 of the CRA for the months of January and February 2016. The corrective action plan indicated a single provider submitted a significant amount of claims which required manual review. AGP added staff to ensure timely adjudication.

AGP submitted to TDCI a corrective action plan for non-compliance with Section A.2.22.4 of the CRA for the month of May 2016. The corrective action plan indicated AGP implemented a manual daily release process for pended claims to correct the delayed adjudication of CHOICES claims.

As of result of the failures to comply with prompt pay claims processing requirements for CHOICES claims, the TennCare Bureau assessed a total of $30,000 in liquidated damages against AGP.

Management Comments

AGP concurs.

Prompt Pay Results for ECF CHOICES HCBS Claims

Pursuant to Section A.2.22.4 of the CRA, AGP is required separately to comply with the following prompt pay claims processing requirements for Employment and Community First (ECF) CHOICES HCBS claims for services submitted electronically in a HIPAA-compliant format:

- Ninety percent (90%) of clean claims ECF CHOICES HCBS shall be processed and paid within fourteen (14) calendar days of receipt.
- Ninety-nine point five percent (99.5%) of clean claims for and ECF CHOICES HCBS shall be processed and paid within twenty-one (21) calendar days of receipt.

As previously mentioned, the ECF program became effective on July 1, 2016. However, claims for ECF CHOICES HCBS services were not received until October 2016. Prompt pay testing determined that ECF CHOICES HCBS claims were processed in compliance with Section A.2.22.4 of the CRA for the months October 2016 through December 2016.

The complete results of TDCI's prompt pay compliance testing can be found at https://www.tn.gov/commerce/article/tncoversight-prompt-pay-compliance-reports.

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,
- Review of the focused claims testing procedures and responses and,
- Review of internal controls related to claims processing.

C. Claims Payment Accuracy

1. Claims Payment Accuracy Reported by AGP

Section A.2.22.6 of the CRA requires that 97% of claims are processed or paid accurately upon initial submission. On a monthly basis, AGP submits claims payment accuracy reports to TennCare based upon audits conducted by AGP. A minimum sample of 160 claims randomly selected from the entire population of electronic and paper claims processed or paid upon initial submission for the month tested is required. Additionally, each monthly sample of 160 claims shall contain a minimum of 30 claims associated with nursing facility (NF) services provided to CHOICES members and 30 claims associated with HCBS provided to CHOICES members. Effective July 1, 2016, the CRA was amended to require the minimum sample of 160 claims to include 30 claims associated with ECF CHOICES HCBS services provided to ECF CHOICES HCBS members. The testing attributes to be utilized by AGP are defined in the CRAs between AGP and the TennCare Bureau. Additionally, subcontractors responsible for processing claims shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor.

AGP reported compliance with the contractual requirement of 97% except for the following:

Month of Filing	Claim Type	Region	Percentage Reported
September 2016	Nursing Facility	East	96%
November 2016	CHOICES HCBS	East	83%
November 2016	CHOICES HCBS	Middle	87%
November 2016	CHOICES HCBS	West	94%

As each failure was reported, TDCI requested AGP to provide corrective action plans. When AGP identified system errors in the corrective action plans, TDCI followed up until the system issue was resolved. The TennCare Bureau assessed a total of $140,000 in liquidated damages against AGP for calendar year 2016 for claims payment accuracy failures.

Management Comments

AGP concurs.

2. Claims Payment Accuracy Reported by the NEMT Subcontractor

ATTACHMENT XI Section A.15.5 of the CRA requires AGP to pay 97% of Non-Emergency Medical Transportation (NEMT) claims accurately upon initial submission. Additionally, ATTACHMENT XI Section A.15.6 of the CRA requires an audit of NEMT claims that complies with the requirements in the CRA regarding a claims payment accuracy audit. The NEMT subcontractor, Tennessee Carriers Inc., performed and reported compliance with monthly claims payment accuracy requirements for all months in calendar year 2016.

3. Procedures to Review the Claims Payment Accuracy Reports

The review of the claims payment accuracy reports included an interview with responsible staff of AGP and the NEMT subcontractor, Tennessee Carriers Inc., to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy reports. The review included verification that the number of claims selected by AGP and the NEMT subcontractor agreed to requirements of Section A.2.22.6 and ATTACHMENT XI Sections A.15.5 and A.15.6 of the CRA. These interviews were followed by a review of the supporting documentation used to prepare the claims payment accuracy reports.

From claims payment accuracy reports prepared by AGP and the NEMT subcontractor for December 2016, TDCI selected for verification all nine claims reported as errors and fifteen judgmentally selected claims reported as accurately processed. 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 A.2.22.6.4 of the CRA.

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

No issues were noted in AGP's procedures for the preparation of the claims payment accuracy reports. Also, no deficiencies were noted with the claims selected for verification from AGP's December 2016 claims payment accuracy reports.

D. Focused Claims Testing

Effective January 1, 2012, the CRA included additional monthly focused claims testing requirements that require AGP to self-test the accuracy of claims processing based on claims selected by TDCI. Unlike random sampling utilized in the claims

payment accuracy reporting, claims related to known claims processing issues or claims involving complex processing rules are judgmentally selected for the focused claims testing. Any results reported from focused claims testing are not intended to represent the percentage of compliance or non-compliance for the total population of claims processed by AGP. The focused claims testing results highlights or identifies claims processing issues for improvement. For examination purposes, TDCI utilized the results of the focused claims testing to evaluate the accuracy of the claims processing system.
For monthly focused claims testing by AGP during calendar year 2016, TDCI judgmentally selected 25 claims per Grand Region from the data files submitted by AGP for prompt pay testing purposes. The focused areas for testing during calendar year 2016 included the following:

- Paid and denied medical claims
- Claims with processing lags over 60 days
- Paid and denied CHOICES nursing facility claims
- Paid and denied CHOICES HCBS claims
- Claims processed by subcontractors
- Claims denied for exceeding timely filing limits
- Data Integrity issues noted during prompt pay testing

1. Results of Focused Claims Testing

Each month, TDCI provided AGP with the claims selected for testing and specified the attributes for AGP to self-test to determine if the claims were accurately processed. For the 900 claims tested for the calendar year 2016, AGP reported at least one attribute error on 155 claims. It should be noted a claim may fail more than one attribute. For the 155 claims, 228 attribute errors were reported by AGP. The following table summarizes the focused claims testing errors reported by AGP for the calendar year 2016:

Attribute Tested	Errors Reported by AGP
Data Entry is Verified with Hardcopy Claim	2
Correct provider is Associated to Claim	1
Authorization Requirements Properly Considered	26
Member Eligibility Correctly Considered	6
Payment Agrees to Provider Contracted Rate	20
TennCare Reductions and Restorations Applied to Payment	0
Duplicate Payment Has Not Occurred	0
Denial Reason Communicated to Provider Appropriate	153
Copayment Correctly Considered	1
Modifier Codes Correctly Considered	5

Other Insurance Properly Considered	6
Patient Liability Correctly Applied	1
Coding-Bundling/Unbundling Properly Considered	0
Application of Benefit Limits Properly Considered	6
Considered Benefit Limit HCBS Provided as Cost Effective Alternative	0
Application of Expenditure Cap for Member in Group 3 Considered	1
Total	228

2. Additional Deficiencies Noted by TDCI During Focused Claims Testing

   TDCI noted the following additional deficiencies as a result of focused claims testing:

   a. Inappropriate Denial Reasons:

      1. For the January 2016 focused claims testing, AGP indicated three claims were incorrectly denied with reason code "UM1 – units exceed UM authorization." AGP's claims processing system was incorrectly applying four units against the authorization for each unit of service paid which prematurely exhausted the available authorized units. On April 28, 2016, AGP submitted a corrective action plan to TDCI indicating the system error was corrected. TDCI verified that the three claims were correctly reprocessed.

      2. For the February 2016 focused claims testing, AGP indicated four claims were incorrectly denied with reason code "G72 – No MCD#/Disclosure Form". AGP stated the disclosure form was received August 13, 2015, but the form was not properly loaded in the claims processing system. AGP submitted a corrective action plan stating the issue has been resolved and impacted claims were reprocessed. TDCI verified that the four claims were correctly reprocessed.

      3. For the April 2016 focused claims testing, AGP indicated that capitated service lines were incorrectly reported with a denied status on the monthly prompt pay file submission to TDCI. AGP corrected future submissions of prompt pay data files. During subsequent monthly testing, TDCI has not found a repeat of the error that occurred during April 2016.

      <u>Management Comments</u>

      AGP concurs.

b. Encounter Data Issues:

In the March 2016 focused claims testing, TDCI discovered that for multiple claims submitted by the vision subcontractor, not all service lines were reported to TennCare as encounter data. The subcontractor indicated that partially and fully denied claims were not submitted as encounter data. As of May 24, 2016, the vision subcontractor agreed to submit all denied claims as encounter data to the TennCare Bureau.

Management Comments

AGP concurs. AGP will be terminating the services contract of Superior Vision, Inc. effective on/or before December 31, 2017.

c. Significant Processing Delays:

1. In the April 2016 focused claims testing, TDCI noted there were two claims that took longer than 60 days for AGP to process. The two claims were improperly considered by AGP as corrected claims versus claims appeals. AGP indicated that the mishandling of these claims was a one-time event. Since these claims were not properly identified as claims appeals, the considerable processing delay violated Tenn. Code Ann. § 56-32-126(b)(2)(A) which 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.

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

- The two claims were not resolved within 60 days and no written agreement with the provider was executed to allow for additional time to resolve the complaint.

Management Comments

AGP concurs. AGP's Intake Department is measured for quality and accuracy, but unfortunately, misroutes still occur where provider claim payment appeals may be mistakenly routed to AGP's Correspondence Inventory. This sometimes leads to AGP not being able to timely resolve a provider claim payment appeal and/or to timely generate an extension letter in case more time is needed for resolution. In order to minimize the impact of misroutes, new Correspondence Inventory is managed to a twenty (20) day turnaround time. This allows for the identification and remediation of misrouted provider claim payment appeals in time for either the disposition of the provider claim payment appeal or the notification to the provider that more time is required.

Also for provider claim payment appeals where AGP may need more than sixty (60) days to resolve and would require written provider agreement for an extension, AGP is making configuration changes to update its Appeals Letter Generation Software. AGP's extension letter beyond 60 days will now contain verbiage to allow providers to acknowledge the extension in writing. Additionally, AGP's provider servicing team will follow up with providers on all extension letters beyond 60 days to ensure written provider agreement has been obtained. AGP configuration changes in its Appeals Letter General Software will be completed by no later than December 2017. Implementation testing will be conducted in a production environment to ensure all changes are performing as expected.

d. System Configuration errors:

For the November and December 2016 focused claims testing, AGP indicated that one claim was incorrectly denied as a result of a system error with the reason code "G43 - PV Coded billed with wrong Type of Bill". AGP had implemented a system configuration change which caused the error. The error impacted 4,557 claims which resulted in a net paid amount of $621,267.06. AGP indicated that all claims have been reprocessed.

Management Comments

AGP concurs. All claims affected by the system configuration issue have been reprocessed. Type of Bill (TOB) codes 022x, 082x, 084x, 089x were set up in AGP's claims system with a service type of Inpatient rather than Outpatient. These TOB codes were set to be globally changed to an Outpatient service type effective 11/1/2016. However, due to human error,

benefit and pricing configuration updates were not in effect at that time. This was identified and the appropriate benefit and pricing updates were made. Additionally, all impacted claims were reprocessed. Re-education was provided to AGP's Benefit Team as to the standard practice that if configuration changes are not completed prior to an effective date, impacted claims are to be pended to allow for adequate testing of configuration.

3. Verification by TDCI of Focused Claims Testing Results

TDCI performed the following procedures to verify the accuracy of AGP reported focused claims testing results:

- TDCI judgmentally selected 48 claims for testing in which no errors were reported by AGP and,
- TDCI judgmentally selected 54 claims for testing in which AGP reported errors.

The following deficiencies were noted by TDCI during the reverification of focused claims testing results:

a. During the review of the 48 no error claims selected for testing, TDCI noted that one claim was denied with the denial reason code "pre-auth not obtained". Despite having an authorization in the system at the time of service, this Electronic Visit Verification (EVV) system claim denied incorrectly. On the date of service, an authorization had been granted and the provider performed the agreed to service. After the date of service, AGP retroactively altered the terms of the authorization. AGP should not alter authorizations after the services have already been performed. Additionally, the claim should have been reported as inaccurately processed by AGP during focused claims testing.

<u>Management Comments</u>

AGP concurs. AGP determined the root cause of this issue to have been as of the result of an AGP authorization representative incorrectly entering a retroactive start date of an authorization that overlapped an existing authorization. AGP agrees that authorizations should not be entered with a retro effective date and is not part of AGP's policy. The AGP authorization representative who entered the authorization is no longer employed in that position and a re-education of all staff has been conducted.

Additionally, AGP in the future will reflect an authorization entered with a retro effective date as a MCO error in its focused claim testing.

b. During the review of the 54 error claims selected for testing, two error claims were not corrected and reprocessed by AGP as of fieldwork during June 2017. AGP should develop controls to ensure that claims identified by AGP as errors during the focused claims testing are corrected in a timely manner.

Management Comments

AGP concurs. AGP has now implemented a process whereby when an error is identified in TDCI's monthly focused claims audit, a report is run to capture all claims associated with the error in order for claims reprocessing. If additional education is required, the claim example is sent to the appropriate workgroup to cascade training and review of processing instructions.

E. Copayment Testing

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

TDCI requested from AGP a listing of the 100 enrollees with the highest accumulated copayments for the period January 1, through December 31, 2016. From the listing, five enrollees were judgmentally selected and all of the claims processed for those enrollees in calendar year 2016 were analyzed to determine if AGP had correctly applied copayment requirements of the CRA based upon the enrollees eligibility status. The following deficiencies were noted:

For two of five enrollees selected for copayment testing, the following errors were discovered in the application of copayments:

- AGP incorrectly applied a copayment of $15 to an enrollee's claim based upon the enrollee's eligibility status.

- AGP incorrectly applied a copayment of $55.21 to an enrollee's claim based upon the enrollee's eligibility status.

Management Comments

AGP concurs. With respect to the incorrect application of the $15 copayment, this error was due to a specific provider negotiating an Urgent Care contract amendment which was not fully executed until January 9, 2017. On the claim date of service, the contract amendment was pending and the claim was processed as a Primary Care Provider (PCP) claim and not an Urgent Care claim. AGP approved an exception to

override the claims denied G96 (Not the member's PCP) to be reprocessed and paid with this exception memo. The PCP copay was taken because this was the provider's status on the date of service. This exception memo affected 2,301 claims and a claims reprocessing project was completed in May 2017. Claims are now processing correctly for this provider under its Urgent Care contract amendment.

With respect to the incorrect application of the $55.21 copayment, this error was due to a system configuration issue specific to when a claim is billed with a date span that is greater than one (1) day. The configuration was incorrect for one CPT code (93005- EKG/ECG (Electrocardiogram). The configuration issue was corrected and a claims reprocessing project was created to correctly pay all affected claims. The reprocessing project is expected to be completed by September 2017. Also, the AGP configuration team conducted an audit of all copay benefits to ensure that all copay benefits were configured correctly. This review was completed in August 2017.

F. 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.

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

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

TDCI requested AGP to provide ten cancelled checks or EFT documentation related to claims previously tested by TDCI. AGP provided the cancelled checks or the proof of EFT. The documents provided agreed with the amounts paid per the remittance advices and no pattern of significant lag times between the issue date and the cleared date was noted.

H. Pended and Unpaid Claims Testing

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

The pended and unpaid data files submitted to TDCI as of June 30, 2017 were reviewed for claims which were unprocessed and exceeded 60 days from the receipt date. The pended and unpaid data file of claims unprocessed by AGP, as well as subcontractors, indicate a total of 5,861 claims exceeding 60 days in

process. Total first submission claims processed by AGP for June 2017 was 516,406. No material liability exists for claims over 60 days.

I. Mailroom and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls is to determine if procedures by AGP ensure that all claims received from providers are either returned to the provider where appropriate or processed by the claims processing system.

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

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

No reportable deficiencies were noted by TDCI during the review of the mailroom and claim inventory controls for AGP and Tennessee Carriers, Inc.

VII. 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.

TDCI judgmentally selected twenty-five (25) provider complaints from the December 2016 AGP claims processing department provider complaint log. The selection criteria included provider complaints with processing lags of less than 30 days, between 30 and 60 days and greater than 60 days.

The following deficiencies were noted for the twenty-five (25) complaints selected:

- Nine of the 25 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.

- Five of the 25 provider complaints selected for testing were not resolved within 60 days and no written agreement with the provider was executed to allow for additional time to resolve the complaint.

  Management Comments

  AGP concurs. AGP's Intake Department is measured for quality and accuracy, but unfortunately, misroutes still occur where provider claim payment appeals may be mistakenly routed to AGP's Correspondence Inventory. This sometimes leads to AGP not being able to timely resolve a provider claim payment appeal and/or to timely generate an extension letter in case more time is needed for resolution. In order to minimize the impact of misroutes, new Correspondence Inventory is managed to a twenty (20) day turnaround time. This allows for the identification and remediation of misrouted provider claim payment appeals in time for either the disposition of the provider claim payment appeal or the notification to the provider that more time is required.

  Also for provider claim payment appeals where AGP may need more than sixty (60) days to resolve and would require written provider agreement for an extension, AGP is making configuration changes to update its Appeals Letter Generation Software. AGP's extension letter beyond 60 days will now contain verbiage to allow providers to acknowledge the extension in writing. Additionally, AGP's provider servicing team will follow up with providers on all extension letters beyond 60 days to ensure written provider agreement has been obtained. AGP configuration changes in its Appeals Letter General Software will be completed by no later than December 2017. Implementation testing will be conducted in a production environment to ensure all changes are performing as expected.

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 30 calendar 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, 2016, TDCI received and processed 428 provider complaints against AGP. The responses by AGP to providers were categorized by TDCI in the following manner:

Previous denial or underpayment reversed in favor of the provider	234
Previous denial or payment upheld	147
Previous denial or underpayment partially reversed in favor of the provider	14
Paid by AGP upon receipt of complaint	4
Other inquiries	20
Ineligible or duplicate complaint	9

TDCI judgmentally selected 25 of these provider complaints for review. The issues raised by the providers were analyzed and questions were posed to AGP for response. Emphasis was placed on discovering deficiencies in the AGP’s claims processing system or provider complaint procedures. No reportable deficiencies were noted by TDCI during the review.

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, 2016, 23 independent reviews were initiated by providers against AGP. The following is a summary of the reviewer decisions:

Reviewer decision in favor of AGP	3
Reviewer decision in favor of the provider	3
Settled for the provider prior to reviewer decision	9
Previous denial or underpayment partially reversed in favor of the provider	0
Ineligible for independent review	7
Rescinded by provider	1

TDCI judgmentally selected five independent reviews for testing. The issues raised by the providers were analyzed and questions were posed to AGP for response. Emphasis was placed on discovering deficiencies in the AGP's claims processing system or provider complaint and appeal procedures. No reportable issues were noted by TDCI in the claims processing system, provider complaint procedures, or independent review procedures.

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. An update of the provider manual was approved by TDCI on December 16, 2016.

E. Provider Agreements

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

Per Section A.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 A.2.12.9 of the CRA reports the minimum language requirements for provider agreements.

A total of forty-two executed provider agreements were requested from the no error claims tested above in section VI.D. The provider agreements selected included five provider agreements executed by the transportation subcontractor, Tennessee Carriers, Inc. Fifteen of the forty-two claims selected were for out of state providers which do not have executed provider agreements. The following deficiency was noted:

> Six of the twenty-seven executed provider agreements provided and tested were not on templates that were approved by TDCI on February 8, 2016. The provider agreements did not contain the most current TennCare regulatory appendix and regulatory language that incorporates CRA amendments 4 and 5.

Management Comments

AGP concurs. In AGP's effort to correct these deficiencies, AGP is in the process of completing a project to bring all provider agreements into compliance with the most current TennCare regulatory appendix and regulatory language that incorporates CRA amendments 4 and 5.

A project plan was submitted to TDCI detailing AGP's contract remediation timeframe for bringing all provider agreements in to compliance. The scope of the project was implemented in two (2) phases. As part of the First Phase, a TDCI approved Amendment-by-Notification was mailed in June 2017 to providers contracted during calendar year 2013 through 2016 to incorporate regulatory language that includes CRA amendments 4 and 5. As to the Second Phase, AGP is in process of bringing into regulatory compliance all providers contracted during calendar year 2007 through 2012. Some agreements will be remediated via amendment and others will need to be re-papered, depending on the age and formatting of the original contract. AGP will complete the Second Phase by no later than December 2017.

F. Provider Payments

Capitation payments made to providers during 2016 were tested to determine if AGP complied with the payment provisions set forth in its capitated provider agreements. Review of payments to capitated providers indicated that all payments were made per the provider contract requirements.

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 A.2.26.3 of the CRA requires all subcontractor agreements and revisions thereto be approved in advance in writing by TDCI, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof.

Five subcontract agreements were judgmentally selected and tested to determine the following: (1) that the subcontract templates were prior approved by TDCI and the TennCare Bureau and (2) that the executed agreements were on approved templates.

- Three of the five executed subcontracts selected for testing have never been submitted to TDCI and the TennCare Bureau for prior approval. For one of the three subcontracts, AGP determined that filing the subcontract with the TDCI and the TennCare Bureau was not necessary. The subcontractor provides financial rewards for completing prenatal, postpartum and well-baby provider visits in the form of a branded reloadable debit card. AGP confirmed that this subcontractor would have no member interaction; however, the subcontractor utilizes member protected health information. The subcontract should have been prior approved by TDCI and the TennCare Bureau.

Management Comments

AGP concurs. AGP acknowledges 3 of the 5 subcontracts were not previously filed with TDCI. AGP submitted the Altegra Health Operations Company subcontract to TDCI on July 24, 2017 and AGP is working to secure TDCI's approval. For the Cenveo and InComm subcontracts, AGP is finalizing negotiations with the subcontractors to ensure the proper exhibits are included in the agreements. AGP plans to submit both subcontracts to TDCI by the end of October 2017. Finally, based on the most recent guidance provided by TDCI related to prior approval for subcontracts, AGP will review its current executed subcontracts by no later than December 2017 to determine if TDCI submission is necessary. Also, AGP will use this guidance for any future subcontract arrangements to determine filing requirements.

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 A.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 A.2.26.8 requires AGP to ensure that subcontractors comply with all applicable requirements of the CRA. Federal and state requirements include, but are not limited to, specific regulations regarding non-discrimination, conflicts of interest, lobbying, and offer of gratuities.

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

I. Non-discrimination

Section A.2.28.2 of the CRA requires AGP to demonstrate compliance with the applicable federal and state civil rights laws, guidance, and policies, including, but not limited to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and the Church Amendments (42 U.S.C. 300a-7), Section 245 of the Public Health Service Act (42 U.S.C. 238n.), and the Weldon Amendment (Consolidated Appropriations Act 2008, Public Law 110-161, Div. G, Sec. 508(d), 121 Stat. 1844, 2209), the CONTRACTOR shall designate a staff person to be responsible for non-discrimination compliance as required in Section A.2.29.1. 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 A.2.28.2 of the CRA.

J. Internal Audit Function

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

The Internal Audit Department of AGP's parent company, Anthem, Inc., performs engagements of AGP specific to its TennCare operations. Additionally, the Internal Audit Department performs monthly claims payment accuracy testing in compliance with Section A.2.21.10 CRA. The results of the specific engagements and results of

monthly claims payment accuracy testing by the Internal Audit Department were considered by TDCI during the current examination.

K. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., Title 56, Chapter 11, Part 2 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-105 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner…." AGP is domiciled in the State of Tennessee and therefore the filing is regulated in Tennessee. No discrepancies were noted in the annual holding company registration filing for AGP received in 2017 for the calendar year 2016.

L. Health Insurance Portability and Accountability Act (HIPAA)

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

AGP's and its subcontractor's current information systems policies and procedures were reviewed in relation to the HIPAA requirements of the CRA. No deficiencies were noted during the review of policies and procedures related to HIPAA requirements.

As previously noted, in the prior examination report for the year ended December 31, 2014, AGP reported in the Notes of the Financial Statements a contingency related to a HIPAA breach. AGP has provided from the Securities and Exchange Commission Form 10-Q as of June 30, 2017, the following updated note to the consolidated financial statements regarding the cyber attack incident.:

> In February 2015, Anthem reported that they were the target of a sophisticated external cyber-attack. The attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many individuals and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be

given that they will not identify additional information that was accessed or obtained.

Upon discovery of the cyber-attack, Anthem took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate our systems and identify solutions based on the evolving landscape. They are providing credit monitoring and identity protection services to those who have been affected by this cyber-attack. They have continued to implement security enhancements since this incident. They have incurred expenses subsequent to the cyberattack to investigate and remediate this matter and expect to continue to incur expenses of this nature in the foreseeable future. They recognize these expenses in the periods in which they are incurred.

Actions have been filed in various federal and state courts and other claims have been or may be asserted against us on behalf of current or former members, current or former employees, other individuals, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber-attack. Federal and state agencies, including state insurance regulators, state attorneys general, the Health and Human Services Office of Civil Rights and the Federal Bureau of Investigation, are investigating events related to the cyber-attack, including how it occurred, its consequences and our responses. In December 2016, the National Association of Insurance Commissioners, or NAIC, concluded its multistate targeted market conduct and financial exam. In connection with the resolution of the matter, the NAIC requested they provide, and they agreed to provide, a customized credit protection program, equivalent to a credit freeze, for our members who were under the age of eighteen on January 27, 2015. No fines or penalties were imposed on them. Although they are cooperating in these investigations, they may be subject to fines or other obligations, which may have an adverse effect on how we operate our business and our results of operations. With respect to the civil actions, a motion to transfer was filed with the Judicial Panel on Multidistrict Litigation, or the Panel, in February 2015 and was subsequently heard by the Panel in May 2015. In June 2015, the Panel entered its order transferring the consolidated matter to the U.S. District Court for the Northern District of California, or the U.S. District Court. The U.S. District Court entered its case management order in September 2015. They filed a motion to dismiss ten of the counts that were before the U.S. District Court. In February 2016, the court issued an order granting in part and denying in part their motion, dismissing three counts with prejudice, four counts without prejudice and allowing three counts to proceed. Plaintiffs filed a second amended complaint in March 2016, and they

subsequently filed a second motion to dismiss. In May 2016, the court issued an order granting in part and denying in part their motion, dismissing one count with prejudice, dismissing certain counts asserted by specific named plaintiffs with or without prejudice depending on their individualized facts, and allowing the remaining counts to proceed. In July 2016, plaintiffs filed a third amended complaint which they answered in August 2016. Fact discovery was completed in December 2016. Plaintiffs filed their motion for class certification and trial plan in March 2017. They filed their opposition to class certification, motions to strike the testimony of three of the plaintiffs' experts and trial plan in April 2017. Prior to those motions being heard, the parties agreed to settle plaintiffs' claims for a total Anthem settlement payment of $115 million and certain non-monetary relief. In June 2017, plaintiffs filed a motion for preliminary approval of the settlement and a motion to continue all case deadlines. In July 2017, the court granted the motion to continue all case deadlines. A hearing on the motion for preliminary approval of the settlement is scheduled for August 2017. Three state court cases related to the cyber-attack are presently proceeding outside of this Multidistrict Litigation. There remain open regulatory investigations into the incident that are not directly impacted by the Multidistrict Litigation settlement.

They have contingency plans and insurance coverage for certain expenses and potential liabilities of this nature and will pursue coverage for all applicable losses; however, the ultimate outcome of their pursuit of insurance coverage cannot be presently determined. They intend to vigorously defend these suits; however, their ultimate outcome cannot be presently determined.

Management Comment

AGP concurs.

M. Conflict of Interest

Section E.28.1 of the CRA 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 AGP in connection with any work contemplated or performed relative to this Contract unless disclosed to the Commissioner, Tennessee Department of Finance and Administration.

Additionally, Section E.28.2, AGP shall include language in all subcontracts and provider agreements and any and all agreements that result from this Contract between AGP and TENNCARE to ensure that it is maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization. Said language may make applicable the provisions of Section E.28 to all subcontracts, provider agreements and all agreements that result from the Contract between AGP and TENNCARE.

Failure to comply with the provisions required by the CRA shall result in AGP paying liquidated damages in accordance with section E.29 of the CRA.

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

N. Episodes of Care Testing

In 2013, the State of Tennessee launched Tennessee's Health Care Innovation Initiative with the goal to move from paying for volume to paying for value with health care providers being rewarded for desirable outcomes: the high quality and efficient treatment of medical conditions and the maintenance of health over time.

One strategy, Episode-Based Payments, focuses on the health care delivered in association with acute healthcare events such as a surgical procedure or an inpatient hospitalization. Retrospective episode-based payment rewards providers who successfully achieve high quality and efficient outcomes during an “episode of care,” a clinical situation with start and end points that may involve multiple independent providers. This approach rewards high-quality care, promotes the use of clinical pathways and evidence-based guidelines, encourages coordination, and reduces ineffective and/or inappropriate care. For each episode type, a principal accountable provider (also referred to as a PAP or Quarterback) is determined based upon the provider deemed to be in the best position to influence the quality and cost of care for the patient. The design of the each episode is aligned for all MCOs. For every enrollee affected, a non-risk adjusted episode spend amount is determined based upon the total cost of claims from all providers that meet design requirements. Risk adjustment is the mechanism that the episode based models use to achieve a comparison between PAPs. The final risk adjustment methodology decisions are made at the discretion of the MCO after analyzing the data. Each MCO runs its own risk adjustment model because there are variations in the population covered and significant risk factors may vary across MCOs. Episode of care rewards and penalties are in addition to the normal claims payment arrangements between an MCO and a provider and do not have an impact on those arrangements. The MCO sends interim quarterly and final annual reports to each PAP to inform them about their performance in the episode-based payment model. The final provider report will notify the PAP of the total average episode cost (risk adjusted) compared to the acceptable or commendable cost thresholds. PAPs that achieve the

commendable cost threshold are rewarded for their high performance in the previous year. PAPs that exceed the acceptable cost threshold are assessed a financial penalty for a share of the amount of costs that were over and above all of their peers.

Beginning with the provider reports issued in August 2016, TDCI, at the request of the Division of Health Care Finance and Administration, began quarterly testing of the accuracy of the reports prepared by the MCOs. From listings of all enrollee episodes in a quarter, TDCI randomly selected a sample and requested supporting provider reports, claims data files, and risk marker supporting files. The provider reports were vouched to supporting claims in the claims data files. Utilizing the design dimensions for each episode-based model, TDCI applied inclusion and exclusion criteria to the claims data files including, but not limited to, the following:

- Age parameters
- Episode period requirements
- Diagnosis codes
- Procedure diagnosis codes
- Procedure codes
- Revenue codes
- Bill types
- Place of service types
- Modifier codes.

The risk marker supporting files were reviewed to determine if the MCO's risk adjustment model was applied consistently for each episode. Other tests included, but were not limited to, verification of claims data files with claims reported to the TennCare Bureau as encounter data. Also, TDCI selected for testing enrollee episodes excluded from the PAPs average cost calculations.

Effective January 1, 2015, MCOs began the implementation of three following retrospective episodes of care:

- Total joint replacement (hips and knees) including diagnostics (e.g. imaging and laboratory tests), professional and facility fees, medical device(s), physical therapy and other forms of post-acute care, pharmaceuticals, and treatment of any complications and/or related readmissions.

- Hospitalization for acute asthma exacerbation including professional and facility fees, post-acute care, care management through the transition to ongoing outpatient care, pharmaceuticals, and treatment of any complications and/or related readmissions.

- Pregnancy including prenatal care, delivery, postpartum care, and treatment of any complications or related readmissions of the mother.

In August 2016, the final reports were issued by the MCOs to providers informing them of their performance for the three types of episodes of care and any applicable reward or penalty for calendar year 2015 episodes. TDCI tested the accuracy of those reports as described above.

For episodes of care reports issued August 2016, TDCI judgmentally selected 25 enrollee episodes for testing which included the following:

- Fifteen episodes of care included in the Principal Accountable Providers' average cost calculations. Five episodes each were selected from Total Joint Replacement (Hip & Knee), Perinatal, and Asthma Acute Exacerbation episodes.

- Ten episodes of care excluded from the Principal Accountable Providers' average cost calculations due to reasons such as patient age, patient co-morbidities, and non-continuous enrollment.

Results of Episodes of Care Testing

Population	Attribute Tested	Errors noted
Episodes included in the PAPs' average cost calculations	Was the episode a valid and properly included episode (i.e. not an episode that should have been classified as an excluded episode)?	0
	Were the costs of all applicable claims included in the total of non-adjusted costs for the episode?	0
	Were applicable risk markers properly identified according to the risk adjustment model adopted by the MCO?	1
	Was the risk adjusted cost of the episode properly calculated according to the risk adjustment model adopted by the MCO?	1
Episodes excluded from the PAPs' average cost calculations	Was the exclusion reason noted in provider reports supported by claims information?	0

An error was noted in the improper identification and application of risk markers for one enrollee. The provider report indicated risk adjusted cost for this enrollee of $10,528 which is understated by $547.14 or 5.2%.

Management Comments

AGP concurs. AGP's data vendor, Optum Solutions, addressed the errors identified by TDCI that resulted in the 5.2% understatement. The root cause of the error was due to incorrectly stated risk weights for a couple of diagnosis codes (valve disorder and hypertension) which resulted in the understatement. The impact is minimal as the affected provider was neither in the Gain Share or Risk Share zone. The problem has been addressed and will not be a concern moving forward into the Calendar Year 2016 Final Reports.

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

Appendix

Previous Examination Findings

The previous examination findings are provided for informational purposes. The following were financial, claims processing and compliance deficiencies cited in the examination by TDCI for the period January 1 through December 31, 2014:

A. Financial Deficiencies

No reportable deficiencies were noted in the prior report and the current report during the performance of financial analysis procedures.

B. Claims Processing Deficiencies

1. AGP failed to achieve claims payment accuracy requirements of 97% per Section 2.22.6 of the CRA for medical claims, home and community-based services (HCBS) and total claims for the month of July 2014.

2. The review of the claims payment accuracy reports testing results for calendar year 2014 indicated the following deficiencies:

   - For one of the twenty claims reported as errors, AGP noted that a medical claim paid based upon an incorrect fee schedule. This error was noted on the December 2014 claims payment accuracy report; however, as of August 14, 2015, the claim had not been reprocessed and the fee schedule had not been corrected in the claims system.

   - For seven of the twenty claims reported as errors, AGP noted these NEMT claims paid based on a fee schedule that was incorrectly loaded in the claims system. This system error was noted by AGP in the April, June, July and September 2014 claims payment accuracy reports; however, the fee schedule was not corrected until January 2015.

   - For one of the twenty claims reported as errors, AGP noted this NEMT claim paid incorrectly because service units were incorrectly entered from the claim. This error was noted by AGP in the December 2014 claims payment accuracy report; however, as of August 14, 2015, the claim had not been reprocessed.

3. The CRA requires AGP to self-test the accuracy of claims processing based on claims selected by TDCI on a monthly basis. For the 300 claims tested for the calendar year 2014, AGP reported at least one attribute error on 44 claims during this focused claims testing.

4. During the review of focused claims testing results, TDCI noted the following additional deficiencies:

    - For one claim in the February 2014 and one claim in the October 2014 focused claims testing, TDCI noted AGP communicated to providers vague denial reasons in the explanation for denied claims. An example of a vague denial reason is “Billing Error”.

    - For one paid claim in April 2014 and one paid claim in August 2014 focused claims testing, the claims submitted by AGP as encounter data were rejected by TennCare because of data compliancy issues. AGP should identify any compliancy issues before the payment of claims.

5. TDCI reviewed 35 claims reported by AGP as being processed correctly during focused claims testing for the calendar year 2014. TDCI noted the following discrepancies:

    - AGP incorrectly denied a claim for services not allowed under contract.

    - AGP incorrectly denied a claim for “inappropriate/missing modifier”.

    - AGP incorrectly denied a claim for “units exceeding authorization”.

    - AGP incorrectly denied a claim for incorrect diagnosis code.

    For the four claims identified above, AGP incorrectly responded to the focused testing attribute “denial reason communicated to the provider appropriate”.

6. During the review of the monthly focused testing results, AGP reported that a claim was originally processed in error with the denial code “duplicate payment”. However, during fieldwork, TDCI and AGP confirmed that the claim was properly processed.

7. For three of five enrollees selected for copayment testing, errors were discovered in the application of copayments. AGP incorrectly applied a copayment of $10 to several of the enrollee's claims based upon the enrollee’s eligibility status.

Findings one, three, four, five, six and seven have been repeated in the current examination.

C. Compliance Deficiencies

1. For the test month of December 2014, the following deficiencies were noted in review of AGP's claim processing provider complaint log:

   - One of the ten complaints selected for testing was 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.

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

2. For one of the 21 provider complaints selected for testing, TDCI noted significant issues in the timely resolution of the provider complaint.

   From the date of the improper recoupment on March 14, 2014, it took 467 days for the provider to obtain repayment from AGP. The plan should redevelop claims appeal procedures to ensure decisions for repayment are properly addressed in a timely manner.

3. The following deficiency was noted during the testing of provider manuals:

   AGP's vision subcontractor, Block Vision Inc., received prior approval from TDCI for their initial submission of their provider manual on January 19, 2007, and an amendment on January 13, 2009. An updated provider manual was submitted to TDCI for prior approval on August 16, 2013. TDCI communicated deficiencies regarding the provider manual submission on September 9, 2013. The deficiencies noted by TDCI have not been corrected, and the provider manual has not been updated to reflect the current CRA regulatory requirements.

4. The following deficiency was noted during the testing of provider agreements:

   For one provider agreement between Block Vision and a vision service provider, the agreement was executed on May 16, 2007. The provider agreement incorporates by reference the provider manuals and updates thereto. As noted above in Section VII.D., the provider manual has not been updated and approved since January 13, 2009. The provider manual has not been updated to reflect the current CRA regulatory requirements.

5. The following deficiencies was noted during the testing of subcontracts:

    - For one of the four subcontracts selected for testing, the contract template was submitted by AGP to TDCI for prior approval on March 19, 2014. AGP corrected several contract language deficiencies noted by TDCI and eventually TDCI approved the contract template on May 27, 2014. The latest executed version of the agreement is dated February 7, 2014, on a contract template version that was not approved by TDCI and which contains several contract language deficiencies.

    - For three of the four subcontracts selected for testing, TDCI noted that the executed agreements have never been submitted to TDCI for approval. Two of the subcontracts are for services related to recovery of claims overpayments to TennCare providers (ACS & Primax). One of the subcontracts is for cellular phone service for specific TennCare enrollees.

6. The following was noted during the review of AGP’s compliance with the Health Insurance Portability and Accountability Act (HIPAA):

    In February 2015, Anthem reported that it was the target of a sophisticated external cyber-attack. The attackers gained unauthorized access to certain of Anthem's information technology systems and obtained personal information related to many of Anthem's current and former members and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses and employment information, including income data. AGP estimates that more than 246,000 current or former AGP TennCare enrollees may have been impacted by the data breach discovered on January 29, 2015.

Findings one, four, five, and six have been repeated in the current examination.