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

VOLUNTEER STATE HEALTH PLAN, INC.
d\b\a BlueCare and
d\b\a TennCare Select

CHATTANOOGA, TENNESSEE

FOR THE PERIOD JANUARY 1, 2013
THROUGH DECEMBER 31, 2013

TennCare Oversight Division • Davy Crockett Tower, 11th Floor • 500 James Robertson Parkway • Nashville, TN 37243
Tel: 615-741-2677 • Fax: 615-401-6834 • tn.gov/commerce

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TO:	Julie Mix McPeak, Commissioner Tennessee Department of Commerce and Insurance
	Darin Gordon, Deputy Commissioner Tennessee Department of Finance and Administration, TennCare Bureau
VIA:	Gregg Hawkins, CPA, Assistant Director Office of the Comptroller of the Treasury Division of State Audit
	Lisa R. Jordan, CPA, Assistant Commissioner Tennessee Department of Commerce and Insurance
	John Mattingly, CPA, TennCare Examinations Director Tennessee Department of Commerce and Insurance
CC:	Larry Martin, Commissioner Tennessee Department of Finance and Administration
FROM:	Gregory Hawkins, CPA, TennCare Examinations Manager Karen Degges, CPA, Legislative Auditor Ronald Crozier, TennCare Examiner Steve Gore, CPA, TennCare Examiner
DATE:	July 14, 2015

The Financial and Compliance Examination and Market Conduct Examination of the TennCare Operations of Volunteer State Health Plan, Inc., Chattanooga, Tennessee, was completed September 12, 2014. The report of this examination is herein respectfully submitted.

I. FOREWORD

On March 6, 2014, the TennCare Oversight Division of the Tennessee Department of Commerce and Insurance (TDCI) notified representatives of Volunteer State Health Plan, Inc., (VSHP) of its intention to perform a Financial and Compliance Examination and Market Conduct Examination of VSHP's TennCare Operations. Fieldwork began on June 9, 2014, and ended on August 14, 2014. All document requests and the signed management representation letter were provided by September 12, 2014.

This report includes the results of the market conduct examination "by test" of the claims processing system for VSHP's TennCare operations. Further, this report reflects the results of an examination of financial statement account balances as reported for TennCare operations by VSHP. This report also reflects the results of a compliance examination of VSHP'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 VSHP was conducted jointly by TDCI and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 2.25 of the East and West Tennessee Grand Regions TennCare Contractor Risk Agreements (CRAs) and the Agreement for the Administration of TennCare Select (AATS) between the State of Tennessee and VSHP, Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) § 56-32-115 and § 56-32-132.

Volunteer State Health Plan, 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, 2013.

The current market conduct examination by TDCI and the Comptroller focused on the claims processing functions and performance for VSHP 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 VSHP'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 VSHP's TennCare operations were administered in accordance with the CRAs, the AATS and state statutes and regulations concerning HMO operations, thus reasonably assuring that VSHP's TennCare enrollees received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether VSHP met certain contractual obligations under the CRAs, the AATS and whether VSHP was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-101 *et seq.*;
- Determine whether VSHP 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 VSHP's TennCare operations properly adjudicated claims from service providers and made payments to providers in a timely manner;
- Determine whether VSHP's TennCare operations had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and
- Determine whether VSHP had corrected deficiencies outlined in prior TDCI examinations of VSHP's TennCare operations.

III. PROFILE

A. Administrative Organization

VSHP is a wholly owned subsidiary of Southern Diversified Business Services, Inc. (SDBS) which is a wholly owned subsidiary of Blue Cross Blue Shield of Tennessee, Inc. (BCBST). BCBST performs certain administrative functions of VSHP through an administrative service agreement between VSHP and BCBST.

The officers and directors or trustees for VSHP as reported on the NAIC Annual Statement for the year ending December 31, 2013, were as follows:

Officers for VSHP

Scott Christian Pierce, President/CEO
Brian Edward Stanza, Treasurer
Shelia Dian Clemons, Secretary
Alaine Marie Zachary, Assistant Treasurer
Katherine Anne Laurance, Assistant Secretary

Administrative Officers for VSHP

Amber Jeanine Cambron, VP, Chief Operating Officer
Reid Allen Smiley, Chief Financial Officer
Tolliver Ralph Woodard, Jr., Controller/Chief Accounting Officer
David Matthew Moroney, MD, VP, Chief Medical Officer
James Howard Sirte, Actuary

Directors or Trustees for VSHP

William Morgan Gracey, Chairperson
Jason David Hickey
John Francis Giblin

B. Brief Overview

Effective November 4, 1996, TDCI granted VSHP (formerly Volunteer State Health Plan II, Inc.) a certificate of authority to operate as a TennCare HMO. VSHP operated this line of business under the plan name BlueCare.

Effective July 1, 2001, VSHP's contract with the TennCare Bureau was limited to enrollment in the East Tennessee Grand Region. Also effective July 1, 2001, VSHP entered into an agreement with the TennCare Bureau to administer a safety net plan called TennCare Select. Under this agreement, the state, and not VSHP, is at risk for the cost of medical services. TennCare Select provides services for children in state custody or at risk of being placed in state custody, children eligible to receive Social Security Income, children receiving services in an institution or under the State's Home and Community Based Service waiver, and TennCare enrollees residing out of state.

For the West Tennessee Grand Region effective November 1, 2008 and the East Tennessee Grand Region effective January 1, 2009, VSHP is contracted through an at-risk agreement with the TennCare Bureau to receive a monthly capitation payment based on the number of enrollees assigned to VSHP and each enrollee's

eligibility classification.

As of December 31, 2013, TennCare Select had approximately 45,600 TennCare members statewide and BlueCare had approximately 209,200 TennCare members for the East Tennessee Grand Region and approximately 174,200 for the West Tennessee Grand Region. The TennCare benefits required to be provided by VSHP are:

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

C. Claims Processing Not Performed by VSHP

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

- Southeastrans, Inc. (SET) for non-emergency medical transportation (NEMT)

- CareCentrix inc., for durable medical equipment (DME) for benefits and claims processing for dates of service ending October 31, 2012 and claims processing run-out through November 30, 2013

- Value Options of Tennessee, Inc., (VOTN) for behavioral health services

Because the TennCare Bureau has contracted with other organizations for the provision of dental and pharmacy benefits, VSHP 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. The claims processing subcontractor for DME claims, CareCentrix Inc., failed to achieve monthly compliance with prompt pay standards for the processing of

DME claims for seven months in the East Tennessee Grand Region, for six months in the West Tennessee Grand Region and for eight months for the TennCare Select contract for the calendar year ending December 31, 2013. It should be noted that the contract with CareCentrix Inc., ended for dates of service October 31, 2012, and prompt pay testing for claims run-out purposes ended for CareCentrix Inc., in November 2013.

(See Section VI.A. of this report)

2. VSHP reported a 96% claims payment accuracy rate for BlueCare long term care nursing facility claims in the West Grand Region for the month of November 2013 which fails to achieve the claims payment accuracy requirements of 97% as required by Section 2.22.6 of the CRAs.

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

3. The subcontractor, Southeastrans, Inc., reported NEMT claims payment accuracy percentages of 94% for June 2013 and 95% for August 2013 for the TennCare Select operations which fails to achieve the 97% claims payment accuracy required by ATTACHMENT XI Section A.15.5 of the AATS.

   (See Section VI.C.2. of this report)

4. The review of the claims payment accuracy report testing procedures and results for December 2013 noted the following deficiencies:

   - Section 2.22.6.4.5 of the CRAs and of the AATS requires VSHP to determine if the allowed payment agrees with the contracted rate. VSHP's claims payment accuracy testing procedures do not confirm the allowed payment to the amount defined in the providers' contract for each claim tested.

   - For one outpatient claim, the amount paid by VSHP for a triage fee could not be verified to the payment terms or fee schedules in the executed provider contract.

   - The claims payment accuracy percentage for December 2013 was erroneously reported because VSHP failed to properly consider a claim that had been processed in error. VSHP should ensure identified errors are properly considered and reported on the claims payment accuracy reports.

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

5. The CRAs and the AATS include additional monthly focused claims testing requirements for VSHP to self-test the accuracy of claims processing based on

claims selected by TDCI. For the 900 claims tested for the calendar year 2013, VSHP reported at least one attribute error on 91 claims.

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

6. During the review of the errors identified as a result of focused claims testing, TDCI noted the following significant claims processing system issues:

   a. The claims system did not always properly consider retro-active eligibility before denying claims which exceeded timely filing limits.

   b. Several claims were incorrectly denied for exceeding timely filing limits. VSHP noted that pro-active reports are utilized to detect claims that potentially will be incorrectly denied for exceeding timely filing limits before final processing. However, VSHP noted the pro-active reports failed to identify these claims and the report criteria should be updated to ensure all affected claims are captured.

   c. The following significant claims adjudication issues related to CHOICES claims submitted via the separate Electronic Visit Verification system (EVV) were noted by TDCI:

      - Several claims were incorrectly denied for lack of prior authorization. The error occurred because VSHP incorrectly applied service units based upon a file provided by the TennCare Bureau.

      - VSHP communicates the procedure code and the modifier to the EVV system based upon the enrollee's plan of care. The provider has the ability to change the modifier in the EVV system and therefore perform a service not authorized in the enrollee's plan of care.

      - The authorizations granted in VSHP's claims processing system are not always in agreement with the authorizations loaded in the EVV system. VSHP indicated that duplicate authorizations may be loaded into the EVV system instead of being replaced by updated authorizations in the EVV system causing billing errors. As a result of the error, providers are able to provide and bill for services not in agreement with the enrollee's plan of care.

      - VSHP incorrectly denied claims for exceeding authorized service units granted because of an unknown issue with the claims processing system software, Trizetto.

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

7. During the review of focused claims testing results, TDCI noted the following additional items:

    a. For four claims in the January 2013 and two claims in the April 2013 focused claims testing, TDCI noted VSHP communicated to providers vague reasons in explanation for denied claims. "The provider must refer to the billing guidelines for proper billing" is an example of a vague reason given for the denial of a claim.

    b. For one claim in the February 2013 and two claims in the May 2013 focused claims testing, VSHP failed to submit the claims as encounter data to the TennCare Bureau. VSHP indicated encounter data submission issues occurred because the claims involved coordination of benefits.

    c. For one paid claim in the December 2013 focused claims testing, VSHP failed to submit the claim as encounter data to the TennCare Bureau. VSHP indicated that the paid claim could not be submitted as encounter data because it failed a compliancy check where the claim's reported from/through dates did not agree with the total days billed per the service lines.

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

8. TDCI reviewed 25 no error claims reported by VSHP during focused claims testing for calendar year 2013. For two outpatient claims, TDCI noted the amount paid by VSHP for a triage fee could not be verified to the payment terms or fee schedules in the executed provider contract. VSHP responded incorrectly to the testing attribute "Payment Agrees to Provider Contracted Rate" for these two claims.

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

9. TDCI reviewed the 91 error claims reported by VSHP during focused claims testing for calendar year 2013. TDCI noted four claims were not reprocessed because VSHP later determined the claims were not originally processed in error. VSHP should more carefully review responses to monthly focused claims testing results.

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

C. Compliance Deficiencies

For three of the nineteen provider appeals selected for testing by TDCI, VSHP did not respond to the provider with an acknowledgement letter that the complete response would require more than 30 days in violation of Tenn. Code Ann. § 56-32-126(b)(2)(A). Additionally for these three appeals, VSHP did not seek to reach an

agreement in writing with the provider that the resolution of these complaints would take longer than 60 days to complete in violation of Tenn. Code Ann. § 56-32-126(b)(2)(A). Further, two of the three provider appeals remained unresolved as of the beginning of examination fieldwork on June 9, 2014.

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

V. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, VSHP 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 VSHP 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, 2013, VSHP reported $478,191,344 in admitted assets, $221,322,024 in liabilities and $256,869,320 in capital and surplus on the 2013 Annual Statement submitted March 1, 2014. VSHP reported total net income of $42,015,897 on the statement of revenue and expenses. The 2013 Annual Statement and other financial reports submitted by VSHP can be found at http://www.tn.gov/commerce/tenncare/mcoreports.shtml.

1. Capital and Surplus

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

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

statements.

Section 2.21.6.1 of the CRAs and AATS requires VSHP 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, 2013, TDCI utilized the greater of (1) the total BlueCare annual premium revenue earned as reported on the NAIC Annual Statement plus TennCare Select payments made to VSHP by the TennCare Bureau for the period ending December 31, 2013, or (2) to the total payments made to VSHP by the TennCare Bureau for BlueCare and TennCare Select for the period ending December 31, 2013.

(1) For the period ending December 31, 2013, VSHP reported BlueCare Premiums of $1,677,051,246 on the NAIC Annual Statement and received TennCare Select payments of $402,417,951 for a total of $2,079,469,197 annual premium revenue.

(2) VSHP received $2,060,366,244 in total payments from the TennCare Bureau for BlueCare and TennCare Select.

Utilizing $2,079,469,197 as the premium revenue base, VSHP's minimum net worth requirement as of December 31, 2013 is $34,942,038 ($150,000,000 x 4% + ($2,079,469,197-150,000,000) x 1.5%). VSHP's reported net worth at December 31, 2013 was $221,927,282 in excess of the minimum required.

2. Restricted Deposit

Tenn. Code Ann. § 56-32-112(b) requires HMOs to establish a restricted deposit and defines the calculation of the deposit based upon annual premium revenue. VSHP's required restricted deposit for the year ending December 31, 2013, is $11,550,000 based on the formula defined in Tenn. Code Ann. § 56-32-112(b). However, Section 2.21.6.2 of the AATS and Section 2.21.6.4 of the CRAs require MCOs to have on deposit an amount equal to the calculated minimum net worth requirement per Section 2.21.6.1 of the CRAs and the AATS.

Utilizing $2,079,469,197 as the premium revenue base, VSHP's restricted deposit requirement as of December 31, 2013 is $34,942,038. Before the filing date of the 2013 NAIC Annual Statement on March 1, 2014, VSHP had on file with TDCI safekeeping receipts totaling $35,640,000 to satisfy restricted deposit requirements.

3. Claims Payable

VSHP reported $142,357,184 claims unpaid as of December 31, 2013, for TennCare operations. The reported amount was certified by a statement of

actuarial opinion. Analysis by TDCI of the triangle lag payment reports through September 30, 2014, for dates of services before January 1, 2014, and review of subsequent NAIC financial filings determined that the reported claims payable for TennCare operations was adequate.

B. TennCare Operating Statement

1. TennCare Operating Statement for Non-Risk Operations for the TennCare Select Program

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

   Although VSHP is under an ASO arrangement as defined by NAIC guidelines, the AATS requires a deviation from ASO reporting guidelines. The required submission of the TennCare Operating Statement should include quarterly and year-to-date revenues earned and expenses incurred as a result of the contractor's participation in the State of Tennessee's TennCare program as if TennCare Select is operating at-risk. As stated in Sections 2.30.16.3.3 and 2.30.16.3.4 of the AATS, VSHP is to provide "an income statement detailing the CONTRACTOR's fourth quarter and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the State of Tennessee's TennCare Program." TennCare HMOs provide this information each quarter on the Report 2A submitted as a supplement to the NAIC financial statements.

2. Sections 2.30.16.3.3 and 2.30.16.3.4 of CRAs require each submission of NAIC financial statements to contain a separate income statement detailing the quarterly and year-to-date revenues earned and expenses incurred as a result of participation in the TennCare program.

No reportable deficiencies were noted in the preparation of the TennCare Operating Statement. The TennCare Operating Statements are separate schedules in the VSHP 2013 NAIC Annual Statement which can be found at http://www.tn.gov/commerce/tenncare/mcoreports.shtml.

C. Medical Fund Target Report

Section 2.30.16.2.1 of the AATS requires that VSHP submit a Medical Fund Target Report (MFT) on a monthly basis. The MFT reports medical payments and IBNR based upon month of service as compared to a target monthly amount for the enrollees' medical expenses. Although estimates for incurred but not reported claims for ASO plans are not included in the NAIC financial statements, these estimates are required to be included in the MFT. VSHP submitted monthly MFT reports which reported actual and estimated monthly medical claims expenditures to be reimbursed by the TennCare Bureau. The estimated monthly expenditures are supported by a letter from an actuary which indicates that the MFT estimates for IBNR expenses have been reviewed for accuracy.

The procedures and supporting documents to prepare the MFT report were reviewed. No discrepancies were noted during the review of documentation supporting the MFT amounts reported.

D. Medical Loss Ratio Report

Section 2.30.16.2.1 of the CRAs requires:

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

The BlueCare medical loss ratio (MLR) reports as submitted on February 12, 2014 for the period July 1, 2013, through December 31, 2013, originally reported an MLR of 83.43% for the East Grand Region and 86.25% for the West Grand Region. TDCI reviewed the BlueCare MLR reports for the same period July 1, 2013, though December 31, 2013, submitted on September 22, 2014, which reported an adjusted MLR of 80.63% for the East Grand Region and 82.09% for the West Grand Region. The reason for the noted decrease in the MLR percentage was due to adjustments of incurred but not reported (IBNR) estimates. Over time, the IBNR estimates can be reduced with the submission and payment of actual claims.

The procedures and supporting documents to prepare the MLR report were

reviewed. No discrepancies were noted during the review of documentation supporting the amounts reported on the MLR report.

E. Administrative Expenses and Management Agreement

For the year ended December 31, 2013, VSHP reported total Administrative Expenses of $242,752,232 which included direct expenses incurred by VSHP and administrative and support services fees paid pursuant to the administrative services agreement between VSHP and BlueCross BlueShield of Tennessee, Inc. (BCBST). Administrative Expenses represented 14.5% of total premium revenue. The administrative services agreement requires BCBST to perform certain administrative and support services necessary for the operation of VSHP. These services include, but are not limited to, finance, management information systems, claim administration, telephonic member and provider services support, legal, regulatory, and provider credentialing.

The fee paid to BCBST for administrative services is based on a management agreement previously approved by TDCI. The fees paid to BCBST 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, 2013, management fees of $108,493,098 were charged to VSHP by BlueCross BlueShield of Tennessee. The management fee represented 6.47% of total premium revenue.

The allocation methodologies utilized by VSHP were reviewed by TDCI. No deficiencies were noted during the review of the management agreement.

F. Schedule of Examination Adjustments to Capital and Surplus

No adjustments are recommended to Capital and Surplus for the period ending December 31, 2013, as a result of the examination of VSHP's TennCare operations.

VI. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames set forth in Tenn. Code Ann. § 56-32-126(b)(1) and Section 2.22.4 of the CRAs and the AATS. 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 VSHP, the DME subcontractor, and the NEMT subcontractor.

All TennCare Operations	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2013	95%	99.8%	**Yes**
February 2013	99%	99.6%	**Yes**
March 2013	99%	99.9%	**Yes**
April 2013	98%	99.8%	**Yes**
May 2013	97%	99.9%	**Yes**
June 2013	99%	100.0%	**Yes**
July 2013	94%	100.0%	**Yes**
August 2013	97%	99.9%	**Yes**
September 2013	97%	99.9%	**Yes**
October 2013	99%	100.0%	**Yes**
November 2013	97%	99.9%	**Yes**
December 2013	97%	100.0%	**Yes**

When combining the results for all claims processed, VSHP was in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for all months in 2013. Additionally, the results of the prompt pay testing separately by region and for TennCare Select were in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for all months in 2013.

Prompt Pay Results for DME Claims

The claims processing subcontractor for DME claims, CareCentrix Inc., failed to achieve monthly compliance with prompt pay standards for the processing of DME claims for seven months in the East Tennessee Grand Region, for six months in the West Tennessee Grand Region and for eight months for TennCare Select during the calendar year ending December 31, 2013. It should be noted that the contract with CareCentrix Inc., ended for dates of service October 31, 2012, and prompt pay testing for claims run-out purposes ended for CareCentrix Inc., in November 2013.

Management Comments
Management concurs. BlueCare Tennessee has handled 100 percent of the DME claims processing for dates of service on or after November 1, 2012

Prompt Pay Results for NEMT Claims

Pursuant to Section 2.22.4 of the CRAs and the AATS, VSHP is required to comply with prompt pay claims processing requirements in accordance with Tenn. Code

Ann. § 56-32-126. In addition, pursuant to ATTACHMENT XI Section A.15.3 and A.15.4 of the CRAs and the Agreement for the Administration of TennCare Select, VSHP is required separately to comply with the following prompt pay claims processing requirements for non-emergency transportation claims (NEMT):

Sections A.15.3 and A.15.4, of ATTACHMENT XI to the CRAs and the AATS, require VSHP 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, Southeastrans, Inc., claims were processed in compliance with Section 2.22.4 of the CRAs and the AATS for all months during the 2013 calendar year.

Prompt Pay Results for CHOICES Claims

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

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

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

Prompt pay testing by TDCI determined that CHOICES claims were processed in compliance with Section 2.22.4 of the CRAs and the AATS for all months during the 2013 calendar year. The complete results of TDCI's prompt pay compliance testing can be found at http://www.tn.gov/tncoversight/promptpaybpm.shtml.

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

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

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

- Prior examination findings related to claims processing,
- Complaints or independent reviews on file with TDCI related to inaccurate claims processing,
- Results of prompt pay testing by TDCI,
- Results reported on the claims payment accuracy reports submitted to TDCI and the TennCare Bureau,
- Review of the preparation of the claims payment accuracy reports, and
- Review of internal controls related to claims processing.

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

C. Claims Payment Accuracy

1. Claims Payment Accuracy Reported by VSHP

Section 2.22.6 of the CRAs and the AATS requires that 97% of claims are processed or paid accurately upon initial submission. On a monthly basis, VSHP submits claims payment accuracy percentage reports to TennCare based upon audits conducted by VSHP. A minimum sample of one hundred and sixty (160) claims randomly selected from the entire population of electronic and paper claims processed or paid upon initial submission for the month tested is required. Additionally, each monthly sample of one hundred and sixty (160) claims shall contain a minimum of thirty (30) claims associated with nursing facility services provided to CHOICES members and thirty (30) claims associated with HCBS provided to CHOICES members. The testing attributes to be utilized by VSHP are defined in CRAs and the AATS between VSHP 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.

VSHP reported a 96% claims payment accuracy rate for the BlueCare West Grand Region TennCare Contract for long term care nursing facility for the

month of November 2013 which fails to achieve the claims payment accuracy requirements of 97%.

Management Comments
Management concurs. The claims audited and found with errors were covered with staff and appropriate training was provided to prevent future errors.

2. Claims Payment Accuracy Reported by the NEMT Subcontractor

ATTACHMENT XI Section A.15.5 of the CRAs and the AATS requires VSHP to pay 97% of NEMT claims accurately upon initial submission. Additionally, ATTACHMENT XI Section A.15.6 of the CRAs and the AATS requires a claims payment accuracy audit of NEMT claims that complies with the requirements in the CRAs and the AATS. The NEMT subcontractor, Southeastrans, Inc., performed and reported compliance with monthly claims payment accuracy requirements for all months in calendar year 2013 except for the months of June at 94% and August at 95% for TennCare Select.

Management Comments
Management concurs. All the claims payment errors that were identified for both June 2013 and August 2013 were related to discrepancies in eligibility information.

BlueCare Tennessee and Southeastrans, Inc. (SET) have made revisions to the eligibility file process, and SET now receives and processes full eligibility files that include all historical information across all lines of business which has corrected this issue.

3. Procedures to Review the Claims Payment Accuracy Reports

The review of the claims payment accuracy reports included an interview with responsible staff of VSHP and the NEMT subcontractor to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy reports. The review included verification that the number of claims selected by VSHP and the NEMT subcontractor agreed to requirements of Sections 2.22.6 and ATTACHMENT XI Section A.15.5 and A.15.6 of the CRAs and the AATS. These interviews were followed by a review of the supporting documentation used to prepare the December 2013 claims payment accuracy reports. From VSHP's December 2013 claims payment accuracy report, TDCI selected for verification 15 claims reported as accurately processed. Since no claims were reported as errors on the December 2013 claims payment accuracy report, no error claims were selected for verification. From the NEMT subcontractor's December 2013 claims payment accuracy report, TDCI selected for verification 5 claims reported as accurately processed. Since no claims were reported as errors on the December 2013 NEMT claims

payment accuracy report, no error claims were selected for verification. For the sample of claims that were reported as accurately processed by VSHP and the NEMT subcontractor, TDCI tested the claims to the attributes required in Section 2.22.6.4 of the CRAs and AATS.

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

For the claims selected for verification from VSHP's and the NEMT subcontractor's December 2013 claims payment accuracy reports, the following deficiencies were noted:

- Section 2.22.6.4.5 of the CRAs and the AATS requires VSHP to determine if the allowed payment agrees with the contracted rate. VSHP's claims payment accuracy testing procedures do not confirm the allowed payment to the amount defined in the providers' contract for each claim tested.

  Management Comments
  Management concurs. BlueCare will evaluate existing processes for enhancement related to testing provider contracts.

- For one outpatient claim, the amount paid by VSHP for a triage fee could not be verified to the payment terms or fee schedules in the executed provider contract.

  Management Comments
  Management concurs and will address as facilities are re-contracted.

- No errors were reported by VSHP to TennCare in the December 2013 claims payment accuracy report. However, the supporting documentation provided to TDCI indicated that two claims were incorrectly processed. To reconcile this discrepancy, VSHP explained to TDCI that the two claims identified as errors by VSHP internal auditors were determined to have been properly processed after internal discussions with VSHP claims processing personnel. TDCI reviewed the two claims in question and noted VSHP had subsequently adjusted the two claims after the report submission. For one claim, TDCI determined the subsequent adjustment was required because of additional circumstances not known at the time of original processing date. However, for the second claim, TDCI determined that the error noted by VSHP internal auditors should not have been overturned and should have been reported as an error on the December 2013 claims payment accuracy report. In discussions with TDCI, VSHP agreed and noted that the situation was investigated due to the timing of the error removal and the request for adjustment. VSHP should ensure identified errors are properly considered and reported on the claims payment accuracy reports.

  Management Comments

Once this situation was brought to our attention, we ran a query of all claims in which Internal Audit QA had assigned a dollar error that were subsequently removed. Another report was generated of all errors that were removed but later adjusted. The results were then investigated for timeliness of the adjustment after the audit, and we analyzed the reason for the adjustment. The results are satisfactory as it appears that the adjustments were due to additional information received, such as retroactive prior authorization, medical records received or pay/chase information received. Our analysis of this matter indicates this is an isolated incident.

D. Focused Claims Testing

Effective January 1, 2012, the CRAs and the AATS include additional monthly focused claims testing requirements that require VSHP to self-test the accuracy of claims processing based on claims selected by TDCI. Unlike random sampling utilized in the claims payment accuracy reporting, the focused claims testing judgmentally selects claims related to known claims processing issues or claims involving complex processing rules. 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 VSHP as the claims sample was not statistically valid. 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 VSHP during calendar year 2013, TDCI judgmentally selected 25 claims from the data files submitted by VSHP for prompt pay testing purposes. The focused areas for testing during calendar year 2013 included but not limited to the following:

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

1. Results of Focused Claims Testing

Each month, TDCI provided VSHP with the claims selected for testing and specified the attributes for VSHP to self-test to determine if the claims were accurately processed. For the 900 claims tested for the calendar year 2013, VSHP reported at least one attribute error on 91 claims. It should be noted a claim may fail more than one attribute. For the 91 claims, 198 attribute errors

were reported by VSHP. The following table summarizes the focused claims testing errors reported by VSHP for the calendar year 2013:

Attribute Tested	Errors Reported by VSHP
Data Entry is Verified with Hardcopy Claim	17
Correct provider is Associated to the Claim	2
Authorization Requirements Properly Considered	9
Member Eligibility Correctly Considered	24
Payment Agrees to Provider Contracted Rate	6
TennCare Rate Reduction and Restorations Applied to Payment	0
Duplicate Payment Has Not Occurred	2
Denial Reasons Communicated to Provider Appropriate	111
Copayment Correctly Considered	0
Modifier Codes Correctly Considered	2
Other Insurance Properly Considered	1
Patient Liability Correctly Applied	12
Coding-Bundling/Unbundling Properly Considered	0
Application of Benefit Limits Properly Considered	0
Considered Benefit Limit HCBS Provided as Cost Effective Alternative	2
Application of Expenditure Cap for Member in Group 3 Considered	1
Inappropriate Processing of an Adjusted Claim (June 2013)	9
Total	198

2. Significant System Issues Identified During Focused Claims Testing

   A review of the claims noted as errors revealed both manual and system errors. The following is a discussion of significant system errors identified:

   a. The claims system did not consider retro-active eligibility before denying claims which exceeded timely filing limits. VSHP responded “A retro-eligibility system fix was implemented in August 2013. The clean-up project was completed in February 2014. However, an issue has been identified with the system fix and a proactive report has been implemented until the corrections can be made.”

   b. Providers submitted claims within timely filing limits, however, the claims were denied for exceeding timely filing limits. VSHP responded “BlueCare

has several Timely Filing pro-active reports to identify incorrect denials prior to these going out on the remittance. The 1/1/13 timely filing changes listed in the CRA, allow for tighter control over these claim denials."

c. Significant claims adjudication issues related to CHOICES claims submitted via the separate Electronic Visit Verification system (EVV) were noted by TDCI during the review of VSHP's monthly focused claims testing. The following system issues were noted:

- VSHP's claims system incorrectly denied service units for lack of prior authorization. The error occurred because VSHP incorrectly applied service units based upon a file provided by the TennCare Bureau. This file represents accumulated services utilized by the member to be coordinated between all MCOs.

  VSHP responded "The current 271U systematic process carves out two weeks of accumulator/limit claims data to try to sync to the file that is submitted. This was set up due to the time delay on the report. When we receive the file, it indicates the new MCO and the "other" MCO. We try to identify if we are the other MCO and adjust the accumulators accordingly. Current logic can inflate the number of units causing denials of subsequent claims." Additionally, VSHP indicated "…we are reviewing internal processes for the CHOICES members since the care coordination staff reaches out to the other MCOs to obtain limits and previous Plans of Care at the time they are made aware of the change."

  Management Comments
  A retroactive eligibility process was put in place to systematically flag these members. In phase two of this project, configuration was added to override authorization denials and timely filing denials within 120 days of our receipt of the eligibility. As a safety precaution, we have also created a pro-active report to catch any of these that may manually be denied in error.

  Management concurs with the 271U finding.

- VSHP communicates the procedure code and the modifier to the EVV system based upon the enrollee's plan of care. The provider has the ability to change the modifier in the EVV system and therefore perform a service not authorized in the enrollee's plan of care.

  VSHP responded "There are controls in the EVV; however, providers still currently have the ability to enter information in the event code field which would cause modifiers to appear on the claim(s). All providers have also been trained to bill according to the authorization they have

been given."

Management Comments
BlueCare Tennessee worked with Sandata to lock down the modifier codes associated with claims submission. Prior to the change, the provider could manually manipulate this data which caused claims to not match the authorizations.

- The authorizations granted in VSHP's claims processing system are not always in agreement with the authorizations loaded in the EVV system. The plan indicated that duplicate authorizations may be loaded into the EVV system instead of being replaced by updated authorizations in the EVV system causing billing errors. As a result of the error, providers are able to provide and bill for services not in agreement with the enrollee's plan of care.

  VSHP responded "A manual clean-up of all affected authorizations was performed in June 2013. Claims were paid or denied based on the authorization within Facets. The system issue was within the EVV."

  Management Comments
  BlueCare Tennessee worked with Sandata to update the file transfer process to ensure authorizations changes were being updated instead of adding additional units to the original authorization.

  BCBST is currently working with Trizetto for a system enhancement to address the authorization unit situation.

- VSHP incorrectly denied claims for exceeding authorized service units granted because of an unknown issue with the claims processing system software, Trizetto.

  VSHP responded that after reviewing claims history there was no clear information on why units were applied to the authorization limits. For some reason units are double counted. The errors related to these claims have been reported to Trizetto.

  Management Comments
  Multiple explanation codes were created in the processing system to address specific denials.

3. Additional Items Noted by TDCI During Focused Claims Testing

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

a. Vague Denial Reasons:

For four claims in the January 2013 and two claims in the April 2013 focused claims testing, TDCI noted VSHP communicated to providers vague reasons in explanation for denied claims. “The provider must refer to the billing guidelines for proper billing” is an example of a vague reason given for denial of a claim. In 2013, VSHP began using new denial codes which provided more specific denials to help the provider understand why the claim is being denied. Also, VSHP indicated they would educate VSHP’s claims processors on the new codes and how to use them.

Management Comments
The vague denial reasons were replaced by specific explanation codes in 2013.

b. Encounter Data Issues:

- Coordination of Benefits (COB):

  For one claim in the February 2013 and two claims in the May 2013 focused claims testing, VSHP failed to submit the claims as encounter data to the TennCare Bureau. VSHP indicated encounter data submission issues occurred because the claims involved COB. VSHP indicated that at the time the errors were discovered modifications to the encounter extract were implemented to better report encounters containing COB information.

- Dates of Service Compliancy Check:

  For one paid claim in the December 2013 focused claims testing, VSHP failed to submit the claim as encounter data to the TennCare Bureau. VSHP indicated that the paid claim could not be submitted as encounter data because it failed a compliancy check where the claim’s reported from/through dates did not agree with the total days billed per the service lines. VSHP should never pay a claim which fails compliancy checks as required by the TennCare Bureau. VHSP provided a corrective action plan on March 11, 2014; however, the plan noted that some claims will continue to be rejected by the TennCare Bureau based upon compliancy checks. VSHP should develop processes to eliminate the payment of claims that fail required compliancy checks.

Management Comments

All four claims mentioned above have been corrected and accepted by the Bureau of TennCare. System modifications were implemented in May 2013 to enhance reporting of COB information. Electronically submitted claims, as well as paper claims scanned through our OCR process, go through both BCBST Corporate Edifecs edits as well as BlueCare specific Edifecs edits prior to entering our adjudication system. Manually keyed claims or claims requiring manual intervention are subjected to multiple levels of editing within the adjudication system, in addition to other software editing.

4. Verification by TDCI of Focused Claims Testing Results

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

- Reviewed a judgmentally selected sample of 25 claims for which no errors were reported by VSHP, and

- Reviewed all 91 claims reported by VSHP as errors.

a. During the review of the 25 no error claims selected for testing, the following deficiency was noted:

For two outpatient claims, the amount paid by VSHP for a triage fee could not be verified to the payment terms or fee schedules in the executed provider contract. VSHP responded incorrectly to the testing attribute “Payment Agrees to Provider Contracted Rate” for these two claims.

Management Comments
Management concurs.

b. During the review of the 91 claims reported by VSHP as errors, the following deficiency was noted:

Four claims were not reprocessed because VSHP later determined the claims were not originally processed in error. VSHP should more carefully review responses to monthly focused claims testing results.

Management Comments
The four claim errors noted were the result of misinterpretation of an attribute related to a sample of adjusted claims. We received clarification from TDCI on this issue.

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 VSHP a listing of the 100 enrollees with the highest accumulated copayments for the period January 1, 2013 through December 31, 2013. From the listing, five enrollees were judgmentally selected and all of the claims processed for those enrollees in calendar year 2013 were analyzed to determine if VSHP had correctly applied copayment requirements of the CRAs and AATS based upon the enrollee's eligibility status. No discrepancies were noted during copayment testing.

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. TDCI selected twenty-five claims for remittance advice testing and 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 VSHP; 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 VSHP to provide ten cancelled checks or EFT documentation related to claims previously tested by TDCI. VSHP 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, 2014 for prompt pay analyses were reviewed for claims which were unprocessed and exceeded 60 days old from receipt date. The pended and unpaid data files of claims unprocessed by VSHP indicate a total of 12,525 claims exceeding 60 days in process. 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 VSHP ensure that all claims received from providers are either returned to the provider where appropriate or processed by the claims

processing system.

The review of mailroom and claims inventory controls by TDCI included interviews with VSHP personnel and review of the mailroom and claims processing flowcharts. A tour of the mailroom was completed and ten claims were selected in the mailroom for testing. At a later date, the received date recorded in the claims processing system was compared to the date the claims were selected by TDCI in the mailroom. For each of the ten claims selected for testing, the received date was correctly entered into the claims processing system or the claim had been rejected and returned to the provider. No additional test work of mailroom procedures was performed.

VII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints Received by VSHP

Provider complaints were tested to determine if VSHP 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 utilized VSHP's December 2013 Level I Provider Appeals Log to verify the timeliness of provider complaint processing. Nineteen provider appeals were judgmentally selected for testing. The following deficiencies were noted:

> For three of the nineteen provider appeals selected for testing, VSHP did not respond to the provider with an acknowledgement letter that the complete response would require more than 30 days in violation of Tenn. Code Ann. § 56-32-126(b)(2)(A). Additionally for these three appeals, VSHP did not seek to reach an agreement in writing with the provider that the resolution of these complaints would take longer than 60 days to complete in violation of Tenn. Code Ann. § 56-32-126(b)(2)(A). Further, two of the three provider appeals remain unresolved as of the beginning of examination fieldwork on June 9, 2014.

Management Comments
BlueCare Tennessee implemented a new process and provided training in November 2014 to address the letter requirements in Tenn. Code Ann. § 56-32-126(b)(2)(A).

B. Provider Complaints Received by TDCI

TDCI offers to providers a complaint process for disputes with TennCare MCOs. Complaints may involve claims payment accuracy and timeliness, credentialing procedures, inability to contact or obtain assistance from the MCO, miscommunication or confusion around MCO policy and procedures, etc. When a provider complaint is received, TDCI forwards the complaint to the MCO for investigation. The MCO is required to respond in writing within 14 days to both the provider and TDCI to avoid assessment of liquidated damages pursuant to the "On Request" report requirements of the CRAs and the AATS. 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, 2013, TDCI received and processed 80 provider complaints against VSHP. The responses by VSHP to providers were categorized by TDCI in the following manner:

Previous denial or payment upheld	30
Previous denial or underpayment reversed in favor of the provider	32
Previous denial or underpayment partially reversed in favor of the provider	4
Paid by VSHP upon Receipt of Complaint	3
Other Inquiries	10
Provider complaint withdrawn by provider	1

TDCI judgmentally selected 10 of these provider complaints for review. The issues raised by the providers were analyzed and questions were posed to VSHP for response. Emphasis was placed on discovering deficiencies in the VSHP's claims processing system or provider complaint procedures. No reportable issues were noted by TDCI in the claims processing system or provider complaint procedures.

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 (e.g, 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, 2013, 47 independent reviews were initiated by providers against VSHP. The following is a summary of the reviewers' decisions as of the report date:

Reviewer decision in favor of the provider	7
Settled for provider	4
Previous denial or underpayment partially reversed in favor of the provider	5
Reviewer decision in favor of VSHP	27
Review request submitted by provider was ineligible	4

TDCI judgmentally selected five independent reviews for testing. The issues raised by the providers were analyzed and questions were posed to VSHP for responses. Emphasis was placed on discovering deficiencies in the VSHP's claims processing system, provider complaint procedures, and independent review 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.

On October 29, 2013, VSHP submitted for prior approval an update to the provider manual. After VSHP corrected noted deficiencies, the update was approved by TDCI on December 3, 2013.

E. Provider Agreements

Agreements between an HMO and providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO as provided by Tenn. Code Ann. § 56-32-103(b)(4). The HMO is required to file a notice and obtain the Commissioner's approval prior to

any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-103(c)(1). Additionally, the TennCare Bureau has defined through contract with the HMO minimum language requirements to be contained in the agreement between the HMO and providers. These minimum contract language requirements include, but are not limited to: standards of care, assurance of TennCare enrollees' rights, compliance with all federal and state laws and regulations, and prompt and accurate payment from the HMO to the provider.

Per Section 2.12.2 of the CRAs and the AATS, all template provider agreements and revisions thereto must be approved in advance by TDCI, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Additionally, Section 2.12.9 of the CRAs and the AATS reports the minimum language requirements for provider agreements.

A total of 25 executed provider agreements were judgmentally selected from the 91 claims tested above in section VI.D. The provider agreements selected included a contract executed by the subcontractor, CareCentrix, Inc.

The executed provider agreements were compared to TDCI prior approved templates. No deficiencies were noted during the review of provider agreements selected for testing.

F. Provider Payments

Capitation payments to providers were tested during 2013 to determine if VSHP complied with the payment provisions set forth in its capitated provider agreements. Review of payments to capitated providers indicated that all payments were made per the provider contract requirements.

G. Subcontracts

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

Five subcontracts were judgmentally selected for testing. The executed subcontracts were compared to TDCI and TennCare Bureau prior approved templates. No deficiencies were noted during the review of the subcontracts selected for testing.

H. Subcontractor Monitoring

The CRAs and the AATS between VSHP and the TennCare Bureau allows VSHP to

delegate activities to a subcontractor. VSHP is required to reduce subcontractor agreements to writing and specify the activities and report responsibilities delegated to the subcontractor. VSHP should monitor the subcontractor's performance on an ongoing basis. Also, VSHP should identify any deficiencies or areas for improvement and determine the appropriate corrective action as necessary. Section 2.26.1 of the CRAs and the AATS states, "If the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6." Additionally Section 2.26.7 requires VSHP to ensure that subcontractors comply with all applicable requirements of the CRAs and the AATS. 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 VSHP to provide documentation of its efforts to monitor subcontractor's compliance with CRAs and the AATS requirements. No deficiencies were noted during the review of VSHP's subcontractor review tools and monitoring efforts.

I. Non-discrimination

Section 2.28 of the CRAs and the AATS requires VSHP to demonstrate compliance with Federal and State regulations of Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age of Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981. Based on discussions with various VSHP staff and a review of policies and related supporting documentation, VSHP was in compliance with the reporting requirements of Section 2.28 of the CRAs and the AATS.

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 VSHP's parent company, Blue Cross and Blues Shield of Tennessee, Inc., performs engagements of VSHP specific to its TennCare operations. Additionally, the Internal Audit Department performs monthly claims payment accuracy testing in compliance with Section 2.21.10 CRAs and AATS. 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…." VSHP 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 VSHP received in 2014 for the calendar year 2013.

L. Health Insurance Portability and Accountability Act (HIPAA)

Section 2.27 of the CRAs and the AATS requires VSHP 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.

VSHP and subcontractor's information systems policies and procedures were reviewed in relation to the HIPAA requirements of the CRAs and the AATS. No deficiencies were noted during the review of policies and procedures related to HIPAA requirements.

M. Conflict of Interest

Section 4.19 of the CRAs and Section 5.19 of the AATS warrant that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to VSHP in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

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

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

The MCO is responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and for including the substance of the CRAs and the AATS conflict of interest clauses in all subcontracts, provider agreements and any and all agreements that result from the CRAs and the AATS.

Testing of conflict of interest requirements of the CRAs and the AATS noted the following:

- The most recently approved provider agreement templates contain the conflict of interest language of the CRAs and the AATS.

- The organizational structure of VSHP includes a compliance officer who reports to the President/CEO.

- VSHP has written conflict of interest policies and procedures in place.

- The written policies and procedures outline steps to report violations.

- Employees complete conflict of interest certificates of compliance annually per the written policy and procedures.

- Internal audits are performed to determine compliance with the conflict of interest requirements of the TennCare CRAs and the AATS.

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

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

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, 2011:

A. Financial Deficiencies

1. No amounts were reported as marketing expenses on Report 2A for TennCare Select. However, marketing expenses were incurred by VSHP for TennCare approved health education and outreach activities as well as general marketing expenses allocated from BCBST. These expenses were incorrectly reported on Report 2A on Line 5604 entitled "Legal Fees, Books, Board and Assoc. fees, Collection fees, etc." instead of Line 52 "Marketing".

2. No amounts were reported as marketing expenses on Report 2A for the East and West Grand Division CRAs. However, marketing expenses were incurred by VSHP for TennCare approved health education and outreach activities as well as general marketing expenses allocated from BCBST. These expenses were incorrectly reported on Report 2A on Line 5604 entitled "Legal Fees, Books, Board and Assoc. fees, Collection fees, etc." instead of Line 52 "Marketing".

None of the financial deficiencies findings have been repeated in the current report.

B. Claims Processing Deficiencies

1. Based on an analysis of the total of all claims processed by VSHP and subcontractors for all contracts with the TennCare Bureau, VSHP was not in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for the month of October 2011. The plan did not maintain compliance with prompt pay standards for 12 months after the October 2011 failure, failing to meet prompt pay standards in January 2012. TDCI assessed against VSHP an administrative penalty pursuant to the authority of Tenn. Code Ann. § 56-32-120 in the amount of $10,000.

2. Based on an analysis of claims processed under each contract with the TennCare Bureau, VSHP was not in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for the month of October 2011 in the East Tennessee Grand Region, the West Tennessee Grand Region and for TennCare Select operations.

3. VSHP's NEMT claims processing subcontractor was not in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for the month of February 2011 in the East Tennessee Grand Region.

4. VSHP's DME claims processing subcontractor was not in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for the period March 1, 2011 through September 30, 2011 in East Tennessee Grand Region, West Tennessee Grand Region and for TennCare Select operations during the calendar year ending December 31, 2011.

5. VSHP's NEMT claims processing subcontractor was not in compliance with the contractually required 97% claims payment accuracy standard for the third quarter 2011 for East and West Tennessee Grand Regions and for the second and third quarters 2011 for the TennCare Select operations.

6. VSHP's NEMT claims processing subcontractor incorrectly excluded adjusted claims from prompt pay data files submitted to TDCI for the purpose of determining compliance with prompt pay standards in Tenn. Code Ann. § 56-32-126(b)(1).

7. For seven of the 152 claims processed by VSHP that were selected for testing, the denial explanation reason code transmitted to the providers did not specify the reason for denial.

8. For one of the 152 claims processed by VSHP that were selected for testing, the claim was denied with the explanation of "not a valid code for reimbursement." The procedure code was billed by the provider with an invalid modifier for reimbursement. The claim should have been denied explaining that the modifier billed with the procedure code was invalid for reimbursement.

9. For one of the 152 claim processed by VSHP that were selected for testing, one service line on the claim was incorrectly denied with the explanation exceeds timely filing limits. The claim was appropriately filed within the timely filing limit of 120 days.
10. For one of the 152 claims processed by VSHP that were selected for testing, a Home Community Based Service was denied because the number of services provided exceeded the amount prior authorized by VSHP's care management system. The claim was submitted by the provider through an electronic verification system (EVV) operated through a VSHP subcontractor. The EVV system failed to properly enforce the authorization limits as determined by VSHP's care management system. Without the enforcement of authorization limits, providers are allowed to bill for services contrary to the amount of services specified in the enrollee's plan of care.

11. VSHP's DME claims processing subcontractor states on remittance advices that all provider claims must be received within 45 days. The statement is contrary to timely filing limits of 120 days per the CRAs and the AATS.

The prior claims processing deficiencies 4, 5, 7, and 10 have been repeated in the current report.

C. Compliance Deficiencies

1. For one transportation provider agreement, the executed agreement did not agree with the version previously approved by TDCI. Per the Agreement for the Administration of TennCare Select and Section 2.12.2 of the CRAs, all template provider agreements and revisions thereto must be approved in advance by TDCI.

2. VSHP experienced difficulties in implementing the requirements of the CHOICES program in the East and West Tennessee Grand Regions. Audits by the TennCare Bureau resulted in the assessment of liquidated damages of $13,050,000 for the CHOICES program. The audits noted VSHP's failure to document contact with new members and the establishment of referrals.

3. TDCI noted in claims testing an issue related to the CHOICES Program. The EVV system failed to properly enforce the authorization limits as determined by VSHP's care management system. Without the enforcement of authorization limits, providers are allowed to bill for services contrary to the amount of services specified in the enrollee's plan of care.

The prior compliance deficiency number 3 is repeated as a finding in the claims processing section of the current report.