Department of Commerce & Insurance

VIA E-MAIL

March 4, 2016

Mr. Al King
President/CEO
AMERIGROUP Tennessee, Inc.
Three Lakeview Place
22 Century Blvd, STE 310
Nashville, TN 37214

Re: Examination of AMERIGROUP Tennessee, Inc. (AGP)
Matter #15-277

Dear Mr. King:

Under this division's authority granted under Section 2.25 of the Contractor risk Agreement (CRA) for the Middle Tennessee Grand Region, Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) § 56-32-115 and § 56-32-132, the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) in conjunction with the Comptroller of the Treasury (Comptroller), the Division of State Audit, performed a market conduct and limited scope financial and compliance examination of AGP for the period January 1, 2014, through December 31, 2014. Attached is the final examination report.

TDCI and the Comptroller appreciate the assistance and cooperation of the AGP staff during our examination. If you have any questions regarding this or other matters, please call me at (615)741-2677.

Sincerely,

John Mattingly, CPA, CISA
TennCare Examinations Director

Attachment

cc: Julie Mix McPeak, Commissioner
Larry Martin, Commissioner, Finance and Administration
Lisa Jordan, Assistant Commissioner
Cris McCoy, TennCare Bureau
Keith Gaither, TennCare Bureau
Patti Killingsworth, TennCare Bureau
Gregg Hawkins, Assistant Director State Audit
Karen Degges, State Audit
Gregory Hawkins, TennCare Examinations Manager
Ronald Crozier, TennCare Examiner
Kenni Howard, CMS
Phillip Bailey, CMS
James Alexander, CMS
Carvin Vaughn, AGP

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, 2014
THROUGH DECEMBER 31, 2014

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Tennessee Department of Commerce and Insurance

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Tennessee Department of Finance and Administration, TennCare Bureau

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

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

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

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

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

DATE: March 4, 2016

The Financial and Compliance Examination and Market Conduct Examination of the TennCare Operations of AMERIGROUP Tennessee Inc., Nashville, Tennessee, was completed September 9, 2015. The report of this examination is herein respectfully submitted.

I. FOREWORD

On April 7, 2015, 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 August 3, 2015, and ended on September 9, 2015. All document requests and the signed management representation letter were provided by September 9, 2015.

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

II. PURPOSE AND SCOPE

A. Authority

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

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

B. Areas Examined and Period Covered

The financial examination focused on selected balance sheet accounts and the TennCare income statement submitted with its National Association of Insurance Commissioners (NAIC) Annual Statement for the year ending December 31, 2014.

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

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

C. Purpose and Objective

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

The objectives of the examination were to:

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

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

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

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

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

III. PROFILE

A. Administrative Organization

AGP was incorporated under the laws of the State of Tennessee on April 26, 2006. AGP was licensed as an HMO by TDCI on March 29, 2007, for the purpose of participating as an MCO in the TennCare program for the Middle Tennessee Grand Region. AGP is a wholly-owned subsidiary of AMERIGROUP Corporation, Virginia Beach, Virginia. On October 2, 2012, TDCI issued an order approving the plan of acquisition filed by WellPoint, Inc., Indianapolis, Indiana, to acquire control of AGP, the Tennessee Corporation. As of December 24, 2012, the transaction to acquire

AGP and AMERIGROUP Corporation by WellPoint, Inc. was completed. On December 3, 2014, WellPoint, Inc. changed its corporate name to 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, 2014, were as follows:

Officers for AGP

Alvin Brock King, President/CEO
Edna Laverne Willingham, Vice President/COO
Kathleen Susan Keifer, Secretary
Jack Louis Young, Vice President/Asst. Secretary
Robert David Kretschmer, Treasurer
Eric Kenneth Noble, Vice President/Asst. Treasurer

Other Officers for AGP

Charles Brian Shipp, Chairperson
Kendall Benjamin Edwards, Vice President, Finance
Mark Daniel Justus, Valuation Actuary

Directors or Trustees for AGP

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

B. Brief Overview

Effective April 1, 2007, AGP entered into a full-risk contract with the TennCare Bureau to provide covered TennCare benefits to enrollees in the Middle Tennessee Grand Region in exchange for a per member per month capitation payment. As of December 31, 2014, AGP had approximately 222,000 TennCare enrollees in the Middle Tennessee Grand Region. The TennCare benefits required to be provided by AGP are:

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

In addition to TennCare operations, in January 2008, AGP began offering a Medicare Advantage Special Needs Plan for those who are eligible for both Medicaid and Medicare. 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, 2014, AGP had approximately 5,700 Medicare enrollees in 25 counties in Middle 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:

- Block 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. 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.

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

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.

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

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.

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

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.

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

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”.

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

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.

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

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.

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

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.

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

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.

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

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.

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

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.

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

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.

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

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.

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

V. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, AGP is required to file annual and quarterly NAIC financial statements in accordance with NAIC guidelines with 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, 2014, AGP reported $428,976,884 in admitted assets, $272,424,525 in liabilities and $156,552,359 in capital and surplus on the 2014 Annual Statement submitted March 1, 2015. AGP reported total net income of $26,120,954 on the statement of revenue and expenses. The 2014 Annual Statement and other financial reports submitted by AGP can be found at http://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, 2014. 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, 2014, 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, 2014:

Reported Capital and Surplus	$156,552,359
Reported Authorized Control Level Risk-Based Capital	$30,703,894
Computed and Required Company Action Level Risk-Based Capital (200% of Authorized Control Level)	$61,407,788

   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 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, 2014, TDCI utilized the total annual premium revenue earned as reported on the NAIC Annual Statement for the period ending December 31, 2014. For the period ending December 31, 2014, AGP reported TennCare premiums of $945,130,554 and Medicare premiums of $64,579,305 for a total of $1,009,709,859 annual premium revenue.

Utilizing $1,009,709,859 as the premium revenue base, AGP's minimum net worth requirement as of December 31, 2014 is $18,895,648 ($150,000,000 x 4% + ($1,009,709,859 -150,000,000) x 1.5%). AGP's reported net worth at December 31, 2014, was $137,656,711 in excess of the required minimum reported.

2. Restricted Deposit

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 $1,009,709,859 as the premium revenue base, AGP's restricted deposit requirement as of December 31, 2014 is $6,250,000. As of December 31, 2014, AGP had on file with TDCI, a depository agreement and properly pledged safekeeping receipts totaling $17,366,000 to satisfy restricted deposit requirements.

3. Claims Payable

AGP reported $79,447,837 claims unpaid as of December 31, 2014. Of the total claims unpaid reported, $71,928,315 represented the claims unpaid for TennCare operations. The reported amount was certified by a statement of actuarial opinion.

Analysis by TDCI of the triangle lag payment reports through June 30, 2015, for dates of services before January 1, 2015, and review of subsequent NAIC financial filings determined that the reported claims payable for TennCare operations was adequate.

B. TennCare Operating Statement

Sections 2.30.16.3.3 and 2.30.16.3.4 of the CRA require each submission of NAIC financial statements to contain a separate income statement detailing the quarterly and year-to-date revenues earned and expenses incurred as a result of participation in the TennCare program. For the year ended December 31, 2014, AGP's TennCare Operating Statement reported Total Revenues of $946,572,100, Medical Expenses of $734,431,470, Administrative Expenses of $141,304,613, Income Tax Expense of $28,363,767 and Net Income of $42,472,250.

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

C. Medical Loss Ratio Report

Section 2.30.16.2.1 of the CRA requires:

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

The medical loss ratio (MLR) reports as submitted on January 21, 2015 for the period July 1, 2014, through December 31, 2014, originally reported an MLR of 86.24%. TDCI reviewed the updated MLR reports for the same period July 1, 2014, though December 31, 2014, submitted on July 21, 2015, which reported an adjusted MLR of 81.34%. The reason for the noted decrease in the MLR percentage was due to adjustments of incurred but not reported (IBNR) estimates. Over time the IBNR estimates can be reduced with the submission and payment of actual claims. The procedures and supporting documents to prepare the MLR report were reviewed.

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

D. Administrative Expenses and Management Agreement

For the year ended December 31, 2014, AGP reported total Administrative Expenses of $163,047,737 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 16.1% 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, 2014, management fees of approximately $96,786,000 were charged to AGP by Anthem Inc. The management fee represented approximately 9.6% of total premium revenue.

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

E. Schedule of Examination Adjustments to Capital and Surplus

No adjustments are recommended to Capital and Surplus for the period ending December 31, 2014, as a result of the examination of AGP's TennCare operations.

VI. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

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

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

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

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

Prompt Pay Results for All Claims Processed

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

AGP Middle All TennCare Operations	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2014	99%	99.9%	**Yes**
February 2014	99%	99.9%	**Yes**
March 2014	99%	100.0%	**Yes**
April 2014	99%	99.9%	**Yes**
May 2014	99%	99.9%	**Yes**
June 2014	99%	99.9%	**Yes**
July 2014	99%	100.0%	**Yes**
August 2014	99%	100.0%	**Yes**
September 2014	99%	100.0%	**Yes**
October 2014	99%	100.0%	**Yes**
November 2014	99%	99.9%	**Yes**
December 2014	99%	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 2014.

Prompt Pay Results for Vision

Prompt pay testing determined that claims processed by the vision contractor, Block Vision, Inc., were in compliance with Section 2.22.4 of the CRA for all months in 2014.

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., claims were processed in compliance with Section 2.22.4 of the CRA for all months in calendar year 2014.

Prompt Pay Results for CHOICES Claims

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

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

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

Prompt pay testing determined that CHOICES claims were processed in compliance with Section 2.22.4 of the CRA for all months in calendar year 2014.

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

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

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

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

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

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

C. Claims Payment Accuracy

1. Claims Payment Accuracy Reported by AGP

Section 2.22.6 of the CRA requires that 97% of claims are processed or paid accurately upon initial submission. On a monthly basis, AGP submits claims payment accuracy percentage reports to TennCare based upon audits conducted by AGP. 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 (NF) services provided to CHOICES members and thirty (30) claims associated with home and community-based care services (HCBS) provided to CHOICES 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. The following table represents claims payment accuracy percentages reported by AGP for the examination period January 1, 2014 through December 31, 2014.

All Claims	Medical	NF	HCBS	Total
January 2014	98%	99%	100%	99%
February 2014	99%	99%	98%	99%
March 2014	97%	99%	100%	98%
April 2014	98%	99%	100%	99%
May 2014	99%	99%	100%	99%
June 2014	98%	97%	100%	98%
July 2014	**95%**	98%	**85%**	**93%**
August 2014	97%	99%	100%	98%
September 2014	97%	97%	100%	98%
October 2014	97%	97%	97%	97%
November 2014	99%	99%	99%	99%
December 2014	98%	98%	100%	98%

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 and total claims for the month of July 2014.

Management Comments
AGP concurs. Most of the claims impacted were related to the July 1, 2014 State Rate Reduction.

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, performed and reported compliance with monthly claims payment accuracy requirements for all months in calendar year 2014.

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, Block Vision and Tennessee Carriers to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy reports. The review included verification that the number of claims selected by AGP and the NEMT subcontractor agreed to requirements of Sections 2.22.6 and ATTCHMENT XI Section A.15.5 and A.15.6 of the CRA. These interviews were followed by a review of the supporting documentation used to prepare the claims payment accuracy reports.
From AGP's and the NEMT subcontractor's claims payment accuracy reports, TDCI selected for verification twenty claims reported as errors and fifteen 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 2.22.6.4 of the CRA.

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

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

- For one of the twenty claims reported as errors, AGP noted in December 2014, that a medical claim paid based upon an incorrect fee schedule. 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 upon an incorrect fee schedule. This system error was noted by AGP on the April, June, July and September 2014 claims payment accuracy reports. The fee schedule was not corrected until January 2015. As of August 14, 2015, the seven claims discovered by AGP as paid in error had not been reprocessed.

- 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 on the December 2014 claims payment accuracy report. As of August 14, 2015, the claim had not been reprocessed.

AGP should develop controls to ensure that claims identified as errors during the claims payment accuracy testing are later reprocessed. For system errors, AGP should ensure the claims system is properly reconfigured and all claims previously paid in error are reprocessed.

Management Comments
AGP concurs. AGP has implemented a process whereby an assigned business analyst follows up to make sure claims that have been identified as errors are reprocessed as well as ensuring all other claims affected by the issue are reprocessed or recouped.

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 2014, TDCI judgmentally selected 25 claims from the data files submitted by AGP for prompt pay testing purposes. The focused areas for testing during calendar year 2014 included 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 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 300 claims tested for the calendar year 2014, AGP reported at least one attribute error on 44 claims. It should be noted a claim may fail more than one attribute. For the 44 claims, 59 attribute errors were reported by AGP. The following table summarizes the focused claims testing errors reported by AGP for the calendar year 2014:

Attribute Tested	Errors Reported by AGP
Data Entry is Verified with Hardcopy Claim	15
Authorization Requirements Properly Considered	1
Payment Agrees to Provider Contracted Rate	4
TennCare Reductions and Restorations Applied to Payment	1
Duplicate Payment Has Not Occurred	2
Denial Reason Communicated to Provider Appropriate	24
Modifier Codes Correctly Considered	1
Other Insurance Properly Considered	11
Total	59

2. Additional Deficiencies Noted by TDCI During Focused Claims Testing

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

a. Vague Denial Reasons:

For one claim in the February 2014 focused claims testing, TDCI noted AGP communicated to the provider the following vague denial reason “covered counter> srv allow CTR+rel hist”. Also, for one claim in the October 2014 focused claims testing, AGP communicated to the provider the following vague denial reason “Billing Error”. Vague denial reasons do not communicate adequately what the provider must do in order to correct the claim.

Management Comments
AGP concurs. **“**Billing Error” is one of the top ten (10) claims explanation codes that AGP is working on to prevent further provider abrasion. A process was implemented whereby notes are added to a claim when “Billing Error” is used.

b. Encounter Data Issues:

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.

Management Comments
AGP concurs. AGP continues to work with its encounter team to submit encounters when not prohibited by TennCare edits.

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:

   - Reviewed a judgmentally selected sample of 35 claims for which no errors were reported by AGP and,

   - Reviewed all 44 claims reported by AGP as errors.

   a. During the review of the 35 no error claims selected for testing, AGP responded incorrectly to the focused testing attribute "denial reason communicated to provider appropriate" for four claims submitted via the electronic verification system (EVV). The following exceptions were noted in the four claims:

      o AGP incorrectly denied a claim for "services not allowed under contract". AGP accepted a prior authorization for services granted by another MCO to a provider to ensure continuity of care for a transferred enrollee. However at the time of acceptance, AGP failed to determine if the provider had been contracted to provide the service.

      o AGP incorrectly denied a claim for "inappropriate/missing modifier". The provider submitted the claim via the EVV system with the modifier granted in the prior authorization from AGP. On the same day the claim was received by AGP from the provider, AGP altered the modifier granted in the prior authorization system causing the claim to deny because the modifier submitted no longer matched the modifier associated with the prior authorization.

      o AGP incorrectly denied a claim for "units exceeding authorization". AGP grants providers prior authorizations for specific units and dates of services based upon schedules agreed to in the enrollee's plan of care. In this instance the number of units available on the authorization had been exhausted since AGP had incorrectly applied previously submitted claims with dates of service not included in this authorization.

      o AGP incorrectly denied a claim for "incorrect diagnosis code". When a prior authorization is granted, AGP transmits to the EVV system relevant claim information including diagnosis codes determined by AGP. The provider relies on the accuracy of the relevant claim information transmitted by AGP to the EVV system. In this instance, AGP incorrectly transmitted a diagnosis code not relevant to the age and the medical condition of the enrollee.

For the four claims identified, the claims were inappropriately denied because of procedural errors made by AGP, not the providers. AGP should more carefully review responses to attributes in the monthly focused claims testing prior to the submission of the report to TDCI. A table identifying adjustments by TDCI to the total number of claim errors reported by AGP for calendar year 2014 can be found below.

Management Comments
AGP concurs. AGP has implemented a process whereby a designated business analyst manages focused claims audits end-to-end. The business analyst works closely with AGP's claims and quality managers to ensure responses are accurate and received timely. Also, the business analyst conducts follow up to ensure that all claims that have been identified as errors are reprocessed and any warranted associate education and/or additional training is completed. Further, AGP will conduct a root cause analysis and review all claims related to the error identified for all providers. For any EVV claims in the focus claims audit, AGP's LTSS Operations team will review and research for root cause and resolution as well.

b. 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. A table identifying adjustments by TDCI to the total number of claim errors reported by AGP for calendar year 2014 can be found below.

Management Comments
AGP concurs.

After verification testing performed by TDCI, the following adjustments were made to the Results of Focused Claims Testing reported by AGP for the 300 claims tested for calendar year 2014:

	Error Claims
Original Errors Reported By AGP	44
Additional Errors Identified by TDCI	4
Errors Claims Incorrectly Reported by AGP	(1)
Adjusted Total	47

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, 2014. From the listing, five enrollees were judgmentally selected and all of the claims processed for those enrollees in calendar year 2014 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 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.

Management Comments
AGP concurs. AGP has corrected the copayment configuration for the applicable enrollee eligibility categories.

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 September 30, 2015, were reviewed for claims which were unprocessed and exceeded 60 days old from receipt date. The pended and unpaid data file of claims unprocessed by AGP, as well as subcontractors, indicate a total of 3,736 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 AGP ensure that all claims received from providers are either returned to the provider where appropriate or processed by the claims processing system.

TDCI did not perform a site visit of the mailroom operations of AGP and its subcontractors, Block Vision, and Tennessee Carriers, 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, Block Vision, and Tennessee Carriers.

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.

AGP maintains two provider complaint logs. One log tracks provider complaints received via the TennCare Bureau and TDCI, while a separate log tracks provider complaints received through AGP's claims processing department. TDCI reviewed five provider complaints from the 2014 TennCare Bureau and TDCI provider complaint log and ten provider complaints from the December 2014 AGP claims processing department provider complaint log. Provider complaints received via the TennCare Bureau and TDCI provider complaint log were responded to in a timely manner. The following deficiencies were noted for the ten complaints selected from the December 2014 AGP claims 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.

- 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.

Management Comments

AGP concurs. AGP implemented a 60-day extension letter agreement template with providers in its Claims Appeals tracking database on 12/1/15. Additionally, AGP is working to implement an automated notification process whereby a reminder email is generated when appeals are approaching the 60-day timeframe to ensure actions are taken to contact the provider for the agreement.

B. Provider Complaints Received by TDCI

TDCI offers to providers a complaint process for disputes with TennCare MCOs. Complaints may involve claims payment accuracy and timeliness, credentialing procedures, inability to contact or obtain assistance from the MCO, miscommunication or confusion around MCO policy and procedures, etc. When a provider complaint is received, TDCI forwards the complaint to the MCO for investigation. The MCO is required to respond in writing within 14 days to both the provider and TDCI to avoid assessment of liquidated damages pursuant to the "On Request" report requirements of the CRA.

If the provider is not satisfied with the MCO's response to the complaint, the provider may seek other remedies to resolve the complaint, including but not limited to, requesting a claims payment dispute be sent to an independent reviewer for resolution or pursuing other available legal or contractual remedies.

For the period January 1 through December 31, 2014, TDCI received and processed 145 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	82
Previous denial or payment upheld	48
Previous denial or underpayment partially reversed in favor of the provider	2
Paid by AGP upon Receipt of Complaint	2
Other inquiries	7
Ineligible or duplicate	4

TDCI judgmentally selected 21 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. For one of the 21 provider complaints selected for testing, TDCI noted significant issues in the timely resolution of the provider complaint as demonstrated in the table below:

8/17/2013	Initial claim payment by AGP
3/14/2014	AGP recouped the claim based on a claims review by a subcontractor
5/6/2014	Provider stated they appealed the recoupment with AGP
5/12/2014	AGP sent provider a letter stating that an additional 30 days would be needed to review the request.
7/3/2014	An appeal file was created from the provider's phone call
7/22/2014	AGP incorrectly advised the provider that the claim would be reprocessed and paid
8/11/2014	AGP's recoupment vendor sent a letter to provider in response to the provider inquiry notifying the provider that AGP's decision was upheld.
3/11/2015	Provider submits complaint to TDCI since no repayment had been received
3/18/2015	TDCI refers complaint to AGP for response
3/31/2015	AGP again notifies provider the claim will be paid
6/24/2015	AGP paid claim

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.

Management Comments
AGP concurs.

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, 2014, 19 independent reviews were initiated by providers against AGP. The following is a summary of the reviewer decisions:

Reviewer decision in favor of the provider	5
Settled for the provider	7
Previous denial or underpayment partially reversed in favor of the provider	3
Ineligible	4

TDCI judgmentally selected seven 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. The following discrepancy was noted:

AGP's vision subcontractor, Block Vision, 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.

Management Comments
AGP concurs. AGP worked with Block Vision on conducting a full regulatory review of its provider manual and will be submitting revisions to TDCI for review and approval.

E. Provider Agreements

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

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

A total of ten executed provider agreements were judgmentally selected from the 35 claims tested above in section VI.D. The provider agreements selected included provider agreements executed by AGP subcontractors, Block Vision and Tennessee Carriers. The following deficiency was noted:

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

Management Comments
AGP concurs. AGP worked with Block Vision on conducting a full regulatory review of its provider manual and will be submitting revisions to TDCI for review and approval.

F. Provider Payments

Capitation payments to providers were tested during 2014 to determine if AGP complied with the payment provisions set forth in its capitated provider agreements. Review of payments to capitated providers indicated that all payments were made per the provider contract requirements.

G. Subcontracts

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

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

- 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. (Equian The Assist Group)

- For three of the four subcontracts selected for testing, TDCI noted that the executed agreements have never been submitted to TDCI for prior 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 (Safelink).

AGP should adhere to Tenn. Code Ann. § 56-32-103(c)(1) and Section 2.26.3 of the CRA. Subcontractor agreements and revisions thereto must be prior approved before execution by TDCI and the TennCare Bureau. AGP should review all subcontracts that involve services required by the CRA or involve direct contact with TennCare enrollees to determine if the subcontracts were prior approved by TDCI and the TennCare Bureau.

Management Comments
AGP concurs. As to the Equian The Assist Group subcontract, AGP is working with the subcontractor to ensure the correct version is signed and resubmitted to TDCI. As to the ACS and Primax subcontracts, Primax was purchased by ACS. AGP submitted the historical Primax subcontract, current ACS agreement and applicable

amendments to TDCI and approval was received on October 29, 2015. As to Safelink, AGP has worked with the subcontractor to ensure the historical Safelink agreement and applicable amendments are submitted to TDCI for review and approval. AGP submitted the SafeLink agreement and amendments on December 29, 2015 to begin the TDCI review process.

H. Subcontractor Monitoring

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

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

I. Non-discrimination

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

J. Internal Audit Function

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

department. The internal audit department should report directly to the board of directors so the department can maintain its independence and objectivity.

The Internal Audit Department of AGP's parent company, 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 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 2015 for the calendar year 2014.

L. Health Insurance Portability and Accountability Act (HIPAA)

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

On AGP's NAIC Annual Statement for the year ended December 31, 2014, AGP reported the following to the Notes of the Financial Statements regarding a contingency related to a HIPAA breach:

> 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. 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 Anthem will not identify additional information that was accessed or obtained.

Currently, Anthem is in the process of determining the extent of this cyber-attack and supporting federal law enforcement efforts to identify the responsible parties. Upon discovery of the cyber-attack, Anthem took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate the systems and identify solutions based on the evolving landscape. Anthem will provide credit monitoring and identity protection services to those who have been affected by this cyber-attack. Anthem has incurred expenses subsequent to the cyber-attack to investigate and remediate this matter and expects to continue to incur expenses of this nature in the foreseeable future. Although Anthem is unable to quantify the ultimate magnitude of such expenses at this time, they may be significant. Anthem will recognize these expenses in the periods in which they are incurred.

Actions have been filed in courts in many states and other claims have been or may be asserted against Anthem on behalf of current or former members, current or former employees, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber-attack. State and federal agencies, including state insurance regulators, state attorneys general, and the Federal Bureau of Investigations, are investigating events related to the cyber-attack, including how it occurred, its consequences and our responses. Although Anthem is cooperating in these investigations, Anthem 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. Anthem has contingency plans and insurance coverage for potential liabilities of this nature, however, the coverage may not be sufficient to cover all claims and liabilities. While a loss from these matters is reasonably possible, the Company cannot reasonably estimate a range of possible losses because our investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

The Company is involved in other pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental and administrative proceedings. These investigations, audits and reviews include

> routine and special investigations by state insurance departments, state attorneys general, the U.S. Attorney General and Federal Agencies. Such investigations could result in the imposition of civil or criminal fines, penalties and other sanctions. The Company believes that any liability that may result from any one of these actions is unlikely to have a material adverse effect on the Company's financial position or results of operations.

Anthem, AGP's parent company, estimated that more than 246,000 current or former AGP TennCare enrollees may have been impacted by the data breach discovered on January 29, 2015. Beginning in March 2015, impacted AGP TennCare enrollees were sent notification letters. Anthem offered 24 months of free identity theft repair and credit monitoring services. As of fieldwork, the results of special investigations by state insurance departments and federal agencies discussed in the footnote have not been released.

During fieldwork, TDCI reviewed AGP's and AGP's subcontractor's information systems policies and procedures in relation to the HIPAA requirements of the CRAs. Additionally, TDCI was provided access to working papers of the external auditor in relation to audited financial statements for the year ended December 31, 2014. The working papers documented tests of current internal controls related to information systems.

Management Comments
AGP concurs.

M. Conflict of Interest

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

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

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

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

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

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

- The most recently approved provider agreement templates contain the conflict of interest language of the CRA.
- The organizational structure of AGP includes a compliance officer who reports to the President/CEO.
- AGP has written conflict of interest policies and procedures in place.
- The written policies and procedures outline steps to report violations.
- Employees complete conflict of interest certificates of compliance annually per the written policy and procedures.
- Internal audits are performed to determine compliance with the conflict of interest requirements of the TennCare CRA.

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

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

Appendix

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, 2012:

A. Financial Deficiencies

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

B. Claims Processing Deficiencies

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

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

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

   - AGP identified an error for one nursing facility claim where the monthly patient liability was incorrectly applied resulting in an incorrect payment amount. The attempt by AGP to correct the error was unsuccessful since AGP did not properly consider the application of the monthly patient liability for other nursing facility claims for the patient in the same month of service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Findings two and four have been repeated in the current examination. Also, findings similar to five, six and seven have been repeated in the current examination.

C. Compliance Deficiencies

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

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

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

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

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

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

     One emergency room claim processed by AGP incorrectly paid $50 as non-emergent even though the diagnosis was an emergency as defined by AGP. A subsequent reprocessing project by AGP incorrectly reversed the payment on this claim to zero dollars. The provider resubmitted the claim and AGP

denied the claim for exceeding timely filing limits. At this point the provider complained to TDCI and AGP reprocessed and paid the claim at the contracted emergency diagnosis rate.

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

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

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

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

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

   Findings one and two have been repeated in the current examination. Also, a finding similar to five has been repeated in the current examination.