STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE OVERSIGHT 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, 2018
THROUGH DECEMBER 31, 2018

TABLE OF CONTENTS

TO: Hogden M. Mainda, Commissioner
Tennessee Department of Commerce and Insurance

Gabe Roberts, Deputy Commissioner
Tennessee Department of Finance and Administration, Division of TennCare

VIA: Carter Lawrence, Deputy Commissioner
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DATE: December 19, 2019

The Financial and Compliance Examination and Market Conduct Examination of the TennCare Operations of AMERIGROUP Tennessee Inc., Nashville, Tennessee, was completed August 21, 2019. The report of this examination is herein respectfully submitted.

I. FOREWORD

On April 10, 2019, 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 July 15, 2019, and ended on July 26, 2019. All document requests and the signed management representation letter were provided by August 21, 2019.

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

II. PURPOSE AND SCOPE

A. Authority

This examination of AGP's TennCare operations was conducted jointly by TDCI and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller), under the authority of Section A.2.25 of the Contractor Risk Agreement (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 Division of TennCare 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, 2018.

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

The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.
The compliance examination focused on AGP's TennCare provider appeals procedures, provider agreements and subcontracts, the demonstration of compliance with non-discrimination reporting requirements, and other relevant contract compliance requirements.

C. Purpose and Objective

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

The objectives of the examination were to:

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

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

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

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

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

III. PROFILE

A. Administrative Organization

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

The officers and directors or trustees for AGP as reported on the NAIC Annual Statement for the year ending December 31, 2018 were as follows:

Officers for AGP

Kristen Louise Metzger, Chairperson
Robert Thomas Garnett, President/CEO
Jack Louis Young, Vice President/Assistant Secretary

Other Officers for AGP

Kathleen Susan Kiefer, Secretary
Vincent Edward Scher, Treasurer
Eric (Rick) Kenneth Noble, Assistant Treasurer

Directors or Trustees for AGP

Kristen Louise Metzger
Robert Thomas Garnett
Catherine Irene Kelaghan
Daniele Ruskin

B. Brief Overview

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

As of December 31, 2018, AGP had approximately 369,000 TennCare members state-wide. The TennCare benefits required to be provided by AGP are:

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

Effective March 1, 2010, the CRA between AGP and the Division of TennCare was amended for the implementation of the CHOICES program. CHOICES is TennCare's program for long-term care services. Long-term care services include care in a nursing home and certain services to help a person remain at home or in the community. Home and Community Based Services (HCBS) are services that include help doing everyday activities that enrollees may no longer be able to do for

themselves as they grow older or if they have a physical disability that prevents them from bathing, dressing, getting around their home, preparing meals, or doing household chores. As of December 31, 2018, AGP had approximately 7,800 enrollees assigned to the CHOICES program.

Effective July 1, 2016, AGP began offering services through the Employment and Community First CHOICES program. Employment and Community First CHOICES is a new program for people of all ages who have an intellectual or developmental disability (I/DD). Services in the new program will help people with I/DD live as independently as possible at home or in the community, not in an institution. If the person lives at home with their family, the services help their family support them to become as independent as possible, work, and actively participate in their communities. Benefits include self-advocacy supports for the person and for their family. Residential services are also covered for adults who need them. As of December 31, 2018, AGP had 612 enrollees in the Employment and Community First CHOICES program.

In addition to TennCare operations, AGP began offering a Medicare Advantage Special Needs Plan for those who are eligible for both Medicaid and Medicare in January 2008. 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, 2018, AGP had approximately 11,800 Medicare enrollees in Tennessee. Effective January 1, 2019, AGP received approval from the Centers for Medicare and Medicaid Services to transfer the Medicare Advantage line of business operated under the Amerigroup Tennessee, Inc. Certificate of Authority to the Amerigroup Texas, Inc. Certificate of Authority.

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:

- Eyequest, for vision benefits and the processing and payment of related claims submitted by vision providers.

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

Because the Division of TennCare 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

1. At December 31, 2018, the NAIC annual statement reports claims unpaid of $131,053,632. Of this amount, $119,956,353 is related to the Medicaid line of business. From January 1, 2019 through June 30, 2019, a total of $130,852,020 has been paid out related to Medicaid claims for dates of services before January 1, 2019. In addition, the June 2019 MLR reported a remaining $5,353,658 IBNR for dates of services before January 1, 2019. Accordingly, claims unpaid per statutory reporting is understated $16,249,325 at December 31, 2018.

   (See Section IV.A.3 of this report)

2. At December 31, 2018, the MLR reported claims incurred but not received ("IBNR") at $114,769,049. From January 1, 2019 through June 30, 2019, a total of $130,852,020 has been paid out related to Medicaid claims for dates of services before January 1, 2019. In addition, the June 2019 MLR reported a remaining $5,353,658 IBNR for dates of services before January 1, 2019. Accordingly, IBNR is understated $21,436,629 at December 31, 2018.

   (See Section IV.C of this report)

B. Claims Processing Deficiencies

1. Prompt pay testing by TDCI determined that the vision subcontractor, Eyequest, did not process claims in compliance with Section A.2.22.4 of the CRA for the month of June 2018.

   (See Section VI.A. of this report)

2. Prompt pay testing by TDCI determined that CHOICES claims were not processed in compliance with Section A.2.22.4 of the CRA for the month of December 2018.

   (See Section VI.A. of this report)

3. Prompt pay testing determined that ECF CHOICES HCBS claims were not processed in compliance with Section A.2.22.4 of the CRA for the month of December 2018.

   (See Section VI.A. of this report)

4. During the review of the November 2018 prompt pay data file, TDCI noted that the non-emergency transportation subcontractor, Tennessee Carriers, Inc., is not submitting the correct denial reasons for denied service lines.

   (See Section VI.A. of this report)

5. AGP failed to achieve claims payment accuracy requirements of 97% per Section A.2.22.6 of the CRA for Nursing Facilities claims in the Middle Region for the month of October 2018 and in the West Region for the month of August 2018.

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

6. During the review of AGP's December 2018 claims payment accuracy report, TDCI noted the following deficiencies:

   - For one claim that AGP tested and determined was inaccurately processed in December 2018, the claim has not been adjusted by AGP as of examination fieldwork during July 2019.

- For one vision claim that AGP tested and determined was accurately processed in December 2018, the claim was denied as a "Duplicate". AGP could not provide TDCI support for the denial reason. Additionally, TDCI noted that since AGP does not have access to the vendor's vision claims processing system, AGP could not demonstrate that they verified a duplicate payment occurred or did not occur when responding to claims payment accuracy testing attributes for vision claims.

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

7. The CRA requires AGP to self-test the accuracy of claims processing based on claims selected by TDCI on a monthly basis. For the 900 claims tested for calendar year 2018, AGP reported at least one attribute error on 59 claims during focused claims testing.

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

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

- For the August 2018 focused claims testing, AGP indicated two claims were incorrectly denied with reason code “QRP- PEGA Service restricted to assigned provider”. AGP stated that TN Health Home files were not processed in production for approximately 45 days due to an Optum eligibility load error.

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

- For the August 2018 focused claims testing, AGP indicated four claims were incorrectly denied with reason code “i26 - principal diagnosis incorrectly coded.” AGP stated that the claims did not appropriately route for adjudication due to a systematic error.

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

- In the September 2018 focused claims testing, AGP indicated four claims were incorrectly denied with reason codes “i26 - principal diagnosis incorrectly coded” or “i56 – duplicate submission”. AGP stated that a coding edit was incorrectly put in place to include the service causing the claims to inappropriately route for adjudication.

  (See Section VI.D.2.a.4. of this report)

- For the October 2018 focused claims testing, TDCI discovered that for multiple claims submitted by the vision subcontractor, denied and zero paid service lines were not reported to TennCare as encounter data.

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

- For the November 2018 focused claims testing, TDCI discovered that for multiple claims submitted by the non-emergency transportation subcontractor, denied service lines were not reported to TennCare as encounter data.

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

- For the November 2018 focused claims testing, the non-emergency transportation subcontractor indicated four claims were incorrectly denied as “not eligible”. Tennessee Carriers stated that while the members were eligible on the dates of service, the system incorrectly processed these claims.

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

- For the December 2018 focused claims testing, AGP indicated that one claim was incorrectly denied with the reason code "G72 – No Medicaid# and/or disclosure form". AGP stated that the system error was due to the incorrect group ID being linked when records were updated for the providers.

  (See Section VI.D.2.a.5. of this report)

9. TDCI reviewed 48 claims reported by AGP as being processed correctly during focused claims testing for the calendar year 2018. Of the 48 claims selected, five were processed by EyeQuest and five were processed by Tennessee Carriers. The following deficiencies were noted by TDCI during the reverification testing of 48 claims in which AGP reported no errors during their focused claims testing results:

   - For five denied claims selected by TDCI for verification, AGP incorrectly responded to TDCI for the focused testing attribute "Denial Reasons Communicated to Provider Appropriately". Three of the five claims were incorrectly denied with the reason code "pre-auth not obtained" since prior authorization for service was obtained or was not required. One claim was incorrectly denied with the reason code "Disallow-not allowed under contract" since the service was allowed under the provider contract with AGP. One claim was incorrectly denied with the denial reason code "The Provider is a Primary Care Provider who was not the member's assigned Primary Care Provider" since the provider was assigned as the member's primary care provider.

   - For two paid claims selected by TDCI for verification, AGP incorrectly responded to TDCI for the focused testing attribute "Payment Agrees to Provider Contracted Rate." The amounts paid for these two claims did not agree with the provider's contracted rate.

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

C. Compliance Deficiencies

1. For the test month of December 2018, the following deficiencies were noted in review of AGP's claim processing provider complaint log:

   - Thirty of the 4,965 provider reconsideration requests were not entered into the log by AGP for more than 30 days after being received from the provider. Since no action was taken on these 30 provider reconsideration requests within 30 days of receipt, AGP failed the timeliness requirement for reconsideration requests set forth in Tenn. Code Ann. § 56-32-126(b)(2)(A).

- Seven of the 25 complaints selected for testing were not resolved within 30 days and AGP failed to inform the provider that a decision would be made within 60 days of receipt.

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

(See Section VII.A. of this report)

2. TDCI reviewed 24 provider complaints and 5 independent reviews submitted to TDCI during calendar year 2018. The following deficiencies were noted in the review:

   - For two of the 24 provider complaints selected for testing, AGP did not correctly review the provider complaint and provide a sufficient first response to TDCI.

   - For three of the 5 independent reviews selected for testing, AGP did not correctly review the providers' reconsideration requests which resulted in the disputes being submitted for independent review.

   - An independent review decision was made in favor of the provider on April 16, 2018. AGP did not pay the provider based on the independent review decision until April 4, 2019. Per TCA 56-32-226b(3), once a reviewer has made a decision requiring the HMO to make payment, the HMO must send payment within 20 days of the date of the reviewer's decision.

   (See Section VII.B. of this report)

3. Two of the thirty-five executed provider agreements provided and tested were not on templates that were approved by TDCI. Ten of the 35 provider agreements selected for testing did not contain the most current TennCare regulatory appendix and regulatory language that incorporates CRA amendments 4 and 5.

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

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

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

   (See Section VII.G. 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, 2018, AGP reported $515,468,373 in admitted assets, $328,308,654 in liabilities and $187,159,719 in capital and surplus on the 2018 Annual Statement submitted March 1, 2019. AGP reported total net income of $14,836,314 on the statement of revenue and expenses. The 2018 Annual Statement and other financial reports submitted by AGP can be found at https://www.tn.gov/commerce/tenncare-oversight/reports/managed-care-organization-financial-reports.html.

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, 2018. 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, 2018, 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, 2018:

Reported Capital and Surplus	$187,159,719
Reported Authorized Control Level Risk-Based Capital	$57,658,360
Computed and Required Company Action Level Risk-Based Capital (200% of Authorized Control Level)	$115,316,720

b. HMO Net Worth Requirement:

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

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

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

To determine the minimum net worth requirement as of December 31, 2018, TDCI utilized the greater of (1) the total annual premium revenue earned as reported on the NAIC Annual Statement for the period ending December 31, 2018, or (2) the total cash payments made to AGP by the Division of TennCare plus premium revenue earned from non-TennCare operations for the period ending December 31, 2018.

(1) For the period ending December 31, 2018, AGP reported total company premium revenues of $1,751,003,218 on the 2018 NAIC Annual Statement (Schedule T total).

(2) For the period ending December 31, 2018, AGP reported total payments from the Division of TennCare of $1,746,187,124 (TennCare cash-excluding PBM), and all other premiums and consideration of $157,390,213 (Schedule T total minus TN Medicaid), for a total of $1,903,577,337.

Utilizing $1,903,577,337 as the premium revenue base, AGP's minimum net worth requirement as of December 31, 2018 is $32,303,660 ($150,000,000 x 4% + ($1,978,050,572 -150,000,000) x 1.5%). AGP's reported net worth at December 31, 2018, was $154,856,059 in excess of the required minimum.

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 all Tennessee earned revenue, the premium revenue base is $1,903,577,337. AGP's calculated restricted deposit requirement as of December 31, 2018 is $10,700,000. As of December 31, 2018, 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 $131,053,632 claims unpaid as of December 31, 2018. Of the total claims unpaid reported, $119,956,353 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, 2019 for dates of services before January 1, 2019, and review of subsequent NAIC financial filings determined that the reported claims payable for TennCare operations was understated by $16,249,325 at December 31, 2018. The following table compares subsequent filings with reported unpaid claims as of December 31, 2018:

Reported Claims Unpaid – TennCare at 12/31/18	($119,956,353)
2019 Claims Payments related to 2018 and prior	$130,852,020
June 2019 IBNR related to 2018 and prior	$5,353,658
Claims Unpaid understatement at 12/31/18	$16,249,325

Management Comment

AGP concurs. The state policy of retroactively enrolling more members than previously observed in 2019 for 2018 dates of service caused the reserve deficiency. AGP's policy was to not hold reserves and recognize expenses for members that were not assigned to AGP by the state at year-end 2018.

The state has continued to retroactively add members for older dates of service in 2019 so this has become a predictable expense. AGP has started the process of reserving for retroactive members that have not yet appeared on the 834 membership files. At year-end, AGP plans on holding reserves to avoid unfavorable restatement from members who will be retroactively assigned to AGP in 2020.

B. TennCare Operating Statement

Sections A.2.30.16.3.3 and A.2.30.16.3.4 of the CRA require each submission of NAIC financial statements to contain a separate income statement detailing the quarterly and year-to-date revenues earned and expenses incurred as a result of participation in the TennCare program. For the year ended December 31, 2018, AGP's TennCare Operating Statement reported Total Revenues of $1,595,714,685, Medical Expenses of $1,305,087,094, Administrative Expenses of $276,263,611, Income Tax Expense of $6,667,076 and Net Income of $7,696,904.

No reportable deficiencies were noted in the preparation of the TennCare Operating Statements for the period ending December 31, 2018. The TennCare Operating Statements are separate schedules in the AGP 2018 NAIC Annual Statement which can be found at https://www.tn.gov/commerce/tenncare-oversight/reports/managed-care-organization-financial-reports.html .

C. Medical Loss Ratio Report

Section A.2.30.16.2.1 of the CRA requires the plan to submit a Medical Loss Ratio Report (MLR) monthly with a cumulative year to date calculation. The MLR reports all TennCare related medical expenses, including ECF CHOICES and costs related to the provision of support coordination, and includes the supporting claims lag tables. Expense allocation shall be based on a generally accepted accounting method that is expected to yield the most accurate results. Shared expenses, including expenses under the terms of a management contract, shall be apportioned pro rata to the contract incurring the expense. The MLR should reconcile to NAIC filings including the supplemental TennCare income statement. The CONTRACTOR shall also reconcile the amount paid as reported on the supporting claims lag tables to the amount paid for the corresponding period as reported on the CONTRACTOR's encounter file submission as specified in Sections A.2.30.18.3 and A.2.23.4 of the CRA.

AGP submits medical loss ratio (MLR) reports for each region on the basis of the State's fiscal year which ends on June 30. The MLR percentage is based upon total medical payments plus incurred but not reported (IBNR) claims estimate divided by capitation revenue net of premium tax. TDCI performs an analysis of each region and for all regions combined. AGP's MLRs for the period July 1, 2018, through December 31, 2018, were submitted January 22, 2019. Based on TDCI's analysis, the combined medical loss ratio with capitation revenue net of premium tax was 97.73% for this period. AGP's June 2019 MLRs were submitted on July 22, 2019. Based on an analysis of AGP's June 2019 MLRs for the period July 1, 2018 through December 31, 2018, the combined medical loss ratio was 97.36%. The reason for the decrease in the MLR percentage was due to adjustments of IBNR estimates. Over time the IBNR estimates can be reduced with the submission and payment of actual claims.

The procedures and supporting documents to prepare the MLR report were reviewed. Analysis by TDCI of the IBNR through June 30, 2019 for dates of services before January 1, 2019, and review of subsequent NAIC financial filings determined that the reported IBNR was understated by $21,436,629 at December 31, 2018. The following table compares subsequent filings with reported IBNR as of December 31, 2018:

Total IBNR at 12/31/18	($114,769,049)
2019 Claims Payments related to 2018 and prior	$130,852,020
IBNR at 6/30/19 related to 2018 and prior	$5,353,658
Total IBNR understatement at 12/31/18	$21,436,629

The December 2018 MLR reported was submitted on January 22, 2019. The NAIC Annual Statement was submitted on March 1, 2019. Adjustments were made to IBNR for TennCare operations for the period December 31, 2018, after the submission of December MLR report. The difference between reported claims unpaid for TennCare operations and IBNR reported on the MLR at December 31, 2018 is due to a methodology change for IBNR as it relates to claims for the years 2016 and 2017.

Management Comments

AGP concurs. The year-end deficiency is addressed in AGP's response to Section V.A.3. Additionally, approximately $7 million of the potential IBNR understatement is due to a reporting error. AGP submitted two (2) versions of the December 2018 MLR report, with the second report correcting several errors in the first submission. When updating the files for submission to TDCI, corrections to AGP's IBNR calculations were overlooked and not reflected in the submitted report. AGP was not aware of this error until TDCI brought the issue to AGP's attention in this request.

Since the December 2018 report, AGP has made a number of improvements to its processes for completing the monthly MLR report that would have prevented this error, including automating the process of completing the final files for submission and creating additional checks for consistency between the internal files used to assemble reporting data and the final files for submission.

D. Administrative Expenses and Management Agreement

For the year ended December 31, 2018, AGP reported total Administrative Expenses of $290,908,471 which included direct expenses incurred by AGP and administrative and support services fees paid pursuant to the management agreement between AGP and Anthem, Inc. Administrative Expenses represented approximately 16.6% 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 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, 2018, management fees/allocated expenses of $197,269,009 were charged to AGP by Anthem Inc. The management fee represented approximately 11.3% of total premium revenue.

The management agreement was previously approved by TDCI and the Division of TennCare. The allocation methodologies utilized by AGP to determine administrative expenses were reviewed by TDCI. No deficiencies were noted during the review of the management agreement.

E. Schedule of Examination Adjustments to Capital and Surplus

The understatement of claims payable noted in Section V.3 of this examination report was analyzed against the excess capital and surplus requirements noted in Section V.1.a. Subsequent to year end NAIC filings, a significant increase was noted in reported claims payable, therefore, an adjustment is not recommended to Capital and Surplus for the period ending December 31, 2018, as a result of the examination of AGP's TennCare operations.

VI. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

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

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

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

Prompt Pay Results for All Claims Processed

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

AGP All TennCare Operations	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2018	98%	99.8%	**Yes**
February 2018	100%	99.9%	**Yes**
March 2018	100%	100.0%	**Yes**
April 2018	100%	100.0%	**Yes**
May 2018	100%	100.0%	**Yes**
June 2018	100%	100.0%	**Yes**
July 2018	100%	100.0%	**Yes**
August 2018	100%	100%	**Yes**
September 2018	100%	99.9%	**Yes**
October 2018	100%	100.0%	**Yes**
November 2018	100%	100.0%	**Yes**
December 2018	100%	100.0%	**Yes**

When combining the results for all claims processed, AGP was in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for all months in 2018.

Prompt Pay Results for Vision

The following table represents the results of prompt pay testing for all TennCare claims processed by Eyequest.

Vision Claims	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2018	100%	100.0%	**Yes**
February 2018	100%	100.0%	**Yes**
March 2018	99%	99.5%	**Yes**
April 2018	100%	100.0%	**Yes**
May 2018	100%	100.0%	**Yes**
June 2018	99%	99.4%	**No**
July 2018	100%	100.0%	**Yes**
August 2018	96%	99.7%	**Yes**
September 2018	99%	99.9%	**Yes**
October 2018	100%	99.7%	**Yes**
November 2018	100%	100.0%	**Yes**
December 2018	100%	100.0%	**Yes**

Prompt pay testing by TDCI determined that the vision claims subcontractor, Eyequest, did not process claims in compliance with Section A.2.22.4 of the CRA for the month of June 2018.

AGP and Eyequest submitted a corrective action plan for non-compliance with the prompt pay requirements for the month of June 2018 to TDCI. The corrective action plan included specific actions to achieve prompt pay compliance:

- Eyequest assigned additional resources for research and resolution of “member not found” claims. Once the claims backlog was addressed, the queue was kept within a 14 day period to ensure prompt pay guidelines are met.

Management Comments

AGP concurs.

Prompt Pay Results for Non-Emergency Medical Transportation (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 AGP and Tennessee Carriers, Inc., processed NEMT claims in compliance with Sections A.15.3 and A.15.4 of ATTACHMENT XI of the CRA for all months in calendar year 2018.

Section A.15.2 of ATTACHMENT XI to the CRA requires AGP to submit encounter data for NEMT claims that meet the standard requirements. During the review of the November 2018 prompt pay data file, TDCI determined that the non-emergency transportation subcontractor, Tennessee Carriers, Inc., is not submitting the correct denial reasons for denied service lines as required by Section A.15.2 of ATTACHMENT XI to the CRA.

Management Comments

AGP concurs. The issue was tied to a reporting defect in Tennessee Carrier's claims encounter reporting which incorrectly defined every denial as a member eligibility denial. The error was confined to nine (9) total claims in November 2018 and one (1) claim in December 2018. Tennessee Carriers has addressed this reporting issue and Tennessee Carriers will resubmit its November 2018 and December 2018 Prompt Pay Reports tied to these ten (10) affected claims by no later December 6, 2019.

Prompt Pay Results for CHOICES Claims

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

- Ninety percent (90%) of clean claims for nursing facility services and CHOICES HCBS shall be processed and paid within fourteen (14) calendar days of receipt.

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

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

CHOICES	Clean claims Within 14 days	All claims Within 21 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2018	99%	99.7%	**Yes**
February 2018	100%	99.9%	**Yes**
March 2018	100%	99.9%	**Yes**
April 2018	99%	99.9%	**Yes**
May 2018	100%	99.9%	**Yes**
June 2018	98%	99.9%	**Yes**
July 2018	99%	100.0%	**Yes**
August 2018	100%	100.0%	**Yes**
September 2018	100%	100.0%	**Yes**
October 2018	95%	100.0%	**Yes**
November 2018	98%	100.0%	**Yes**
December 2018	90%	98.9%	**No**

Prompt pay testing determined that nursing facility and CHOICES HCBS claims were not processed in compliance with Section A.2.22.4 of the CRA for the month of December 2018.

AGP submitted to TDCI a corrective action plan for non-compliance with Section A.2.22.4 of the CRA for the month of December 2018. The corrective action plan indicated that claims were not paid within the 14 day prompt pay metric due to a product ID not being included in the check run in December 2018. AGP implemented an audit process to ensure that whenever the check cycles are updated, all products and/or product IDs are added as appropriate. The claims that were not paid within the 21 day prompt pay metric was due an atypical provider pended file failure. AGP corrected the provider file name and reeducated the electronic data interchange team to ensure that no special characters are in the naming convention.

As of result of the failures to comply with prompt pay claims processing requirements for CHOICES claims, the Division of TennCare assessed a total of $10,000 in liquidated damages against AGP.

Management Comments

AGP concurs. Additionally, AGP updated its written desktop process to address the exclusion of special characters in provider claim files.

Prompt Pay Results for ECF CHOICES HCBS Claims

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

- Ninety percent (90%) of clean claims ECF CHOICES HCBS shall be processed and paid within fourteen (14) calendar days of receipt.

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

Prompt pay testing by TDCI determined that ECF CHOICES claims were processed as reported in the following table:

ECF CHOICES	Clean claims Within 14 days	All claims Within 21 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2018	100%	100.0%	**Yes**
February 2018	100%	100.0%	**Yes**
March 2018	99%	100.0%	**Yes**
April 2018	100%	100.0%	**Yes**
May 2018	100%	100.0%	**Yes**
June 2018	97%	100.0%	**Yes**
July 2018	95%	100.0%	**Yes**
August 2018	100%	99.9%	**Yes**
September 2018	100%	99.9%	**Yes**
October 2018	98%	100.0%	**Yes**
November 2018	93%	99.9%	**Yes**
December 2018	77%	99.3%	**No**

Prompt pay testing determined that ECF CHOICES HCBS claims were not processed in compliance with Section A.2.22.4 of the CRA for the month of December 2018.

AGP submitted to TDCI a corrective action plan for non-compliance with Section A.2.22.4 of the CRA for the month of December 2018. The corrective action plan indicated that claims were not paid within the 14 day prompt pay metric due to a product ID not being included in the check run in December 2018. AGP implemented an audit process to ensure that whenever the check cycles are updated, all products and/or product IDs are added as appropriate. The claims that were not paid within the 21 day prompt pay metric was due an atypical provider pended file failure. AGP corrected the provider file name and reeducated the electronic data interchange team to ensure that no special characters are in the naming convention.

As of result of the failures to comply with prompt pay claims processing requirements for ECF CHOICES HCBS claims, the Division of TennCare assessed a total of $10,000 in liquidated damages against AGP.

Management Comments

AGP concurs. Additionally, AGP updated its written desktop process to address the exclusion of special characters in provider claim files.

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

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 Division of TennCare,
- Review of the preparation of the claims payment accuracy reports,
- Review of the focused claims testing procedures and responses and,
- Review of internal controls related to claims processing.

C. Claims Payment Accuracy

1. Claims Payment Accuracy Reported by AGP

Section A.2.22.6 of the CRA requires that 97% of claims are processed or paid accurately upon initial submission. On a monthly basis, AGP submits claims payment accuracy reports to the Division of TennCare and TDCI 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 CRA between AGP and the Division of TennCare. Additionally, subcontractors responsible for processing claims shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor.

AGP failed to achieve the contractual requirement of 97% claims payment accuracy during calendar year 2018 for the following regions, months, and claim types:

Month of Filing	Claim Type	Region	Percentage Reported
August 2018	Nursing Facility	West	95%
October 2018	Nursing Facility	Middle	95%

As each failure was reported, TDCI requested AGP to provide corrective action plans. When AGP identified system errors in the corrective action plans, TDCI followed up on the corrective action plans until the system issues were resolved. The Division of TennCare assessed AGP a total of $20,000 in liquidated damages during 2018 related to claims payment accuracy failures.

Management Comments

AGP concurs. For AGP's August 2018 claims payment accuracy result, there were four (4) claims identified as having payment errors. The root cause of the errors were manual claims analyst processing errors. The analyst failed to review AGP's Change of Ownership (CHOW) provider list prior to denying the claims for no authorization. AGP updated its claims processing instruction (PI) to clearly illustrate the steps needed to process a CHOW claim. To mitigate against future errors, a claims "warning" message was configured in AGP's claims system that instructs claims analysts to review the CHOW PI and claims analyst retraining was conducted. In October 2019, there were additional claims identified as having payment errors. The root cause of these errors were attributable to manual claims analyst processing errors. It was discovered that the warning message referenced above had not been moved to production. Escalation efforts were taken and the programming was moved to production and AGP made an additional update to its CHOW PI by providing an actual intranet web link to active CHOW Providers for claims analyst ease of access.

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 CRA’s claims payment accuracy audit requirements. The NEMT subcontractor, Tennessee Carriers Inc., performed and reported compliance with monthly claims payment accuracy requirements for all months in calendar year 2018.

3. Procedures to Review the Claims Payment Accuracy Reports

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

From claims payment accuracy reports prepared by AGP and the NEMT subcontractor for December 2018, TDCI judgmentally selected for verification eight 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, TDCI tested these claims to the attributes required in Section A.2.22.6.4 of the CRA.

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

The following deficiencies were noted with the procedures for the preparation of claims payment accuracy reports and the results of TDCI's verification of claims selected for testing from AGP's December 2018 claims payment accuracy reports:

- For one claim that AGP tested and determined was inaccurately processed in December 2018, the claim has not been adjusted by AGP as of examination fieldwork during July 2019.

- For one vision claim that AGP tested and determined was accurately processed in December 2018, the claim was denied as a "Duplicate". AGP could not provide TDCI support for the denial reason. Additionally, TDCI noted that since AGP does not have access to the vendor's vision claims processing system, AGP could not demonstrate that they verified a duplicate payment occurred or did not occur when responding to claims payment accuracy testing attributes for vision claims.

Management Comments

AGP concurs. As to the first referenced claim, it was initially denied correctly for units exceeding utilization management authorization. The provider billed attendant care and was to submit corrected claims for personal care. The provider rebilled twenty-three (23) claims for the affected member for personal

care and failed to mark the claims as corrected. In another claim, AGP had paid the provider in error for attendant care for the affected member. AGP initially authorized as attendant care and the provider billed and was reimbursed for attendant care. AGP has updated the authorization to reflect personal care services and the provider must submit the corrected claim before AGP can reprocess claims. AGP is working with the provider on the resubmission of corrected claims.

As to the second referenced claim, AGP's Claims Quality Assurance team will now reach out to the vision vendor for proof of duplicate payments and/or supporting claims information for payment accuracy testing of vision vendor claims.

D. Focused Claims Testing

CRA Section A.2.22.7 requires AGP to monthly self-test the accuracy of claims processing based on claims selected by TDCI. Unlike the 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 highlight or identify 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 2018, TDCI judgmentally selected 25 claims per Grand Region from the data files submitted by AGP for prompt pay testing purposes. The focused areas for testing during calendar year 2018 included the following:

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

1. Results of Focused Claims Testing

Each month, TDCI provided AGP with the claims selected for testing and specified the attributes for AGP to self-test to determine if the claims were accurately processed. For the 900 claims tested for the calendar year 2018, AGP reported at least one attribute error on 59 claims. It should be noted a claim

may fail more than one attribute. For the 59 claims, 94 attribute errors were reported by AGP. The following table summarizes the focused claims testing errors reported by AGP for the calendar year 2018:

Attribute Tested	Errors Reported by AGP
Data Entry is Verified with Hardcopy Claim	2
Correct Provider is Associated to Claim	3
Authorization Requirements Properly Considered	25
Denial Reason Communicated to Provider Appropriate	58
Modifier Codes Correctly Considered	1
Other Insurance Properly Considered	5
Total	94

For the 59 claims that contained attribute errors, AGP identified 13 that were the result of system errors and 46 that were the result of manual errors. For the system errors, AGP provided explanations which identified the error that occurred, identified the number of claims affected, and reported when all affected claims had been reprocessed. TDCI requested corrective action plans when additional explanation was deemed necessary. In subsequent monthly focused testing, TDCI selected similar claim types or claim denial reasons to monitor the resolution of system issues.

Management Comments

AGP concurs.

2. Deficiencies Noted by TDCI During Focused Claims Testing

TDCI noted claims processing deficiencies in addition to the errors identified by AGP during monthly focused testing. For each deficiency, TDCI requested AGP provide additional explanation including the resolution of system configuration issues and the reprocessing of the error claim and all other claims affected by the processing error. The following represent the significant additional items noted by TDCI during monthly focused testing for calendar year 2018:

a. Inappropriate Denial Reasons:

1. For the August 2018 focused claims testing, AGP indicated two claims were incorrectly denied with reason code “QRP- PEGA Service restricted to assigned provider”. AGP stated that TN Health Home files were not processed in production for approximately 45 days due to an Optum eligibility load error. AGP submitted a corrective action plan to TDCI stating the issue had been resolved and that all 8,727 impacted claims had been reprocessed.

2. For the August 2018 focused claims testing, AGP indicated four claims were incorrectly denied with reason code “i26 - principal diagnosis incorrectly coded.” AGP stated that the claims did not appropriately route for adjudication due to a systematic error. AGP submitted a corrective action plan to TDCI stating the issue had been resolved and that all 3,535 impacted claims had been reprocessed.

3. In the September 2018 focused claims testing, AGP indicated four claims were incorrectly denied with reason codes “i26 - principal diagnosis incorrectly coded” or “i56 – duplicate submission”. AGP stated that a coding edit was incorrectly put in place to include the service causing the claims to inappropriately route for adjudication. AGP submitted a corrective action plan to TDCI stating that the coding edit was corrected, and all 3,859 impacted claims had been reprocessed.

4. For the December 2018 focused claims testing, AGP indicated that one claim was incorrectly denied with the reason code “G72 – No Medicaid# and/or disclosure form”. AGP stated that the system error was due to the incorrect group ID being linked when records were updated for the providers. AGP submitted a corrective action plan to TDCI stating that work to ensure all providers were linked to the correct group ID had been completed and that a total of 1,360 impacted claims had been reprocessed.

   Management Comments

   AGP concurs.

b. Encounter Data Issues:

1. For the October 2018 focused claims testing, TDCI discovered that for multiple claims submitted by the vision subcontractor, denied and zero paid service lines were not reported to TennCare as encounter data. As of February 2019, Eyequest, the vision subcontractor, agreed to submit all denied service lines as encounter data to the Division of TennCare.

2. For the November 2018 focused claims testing, TDCI discovered that for multiple claims submitted by the non-emergency transportation subcontractor, denied service lines were not reported to TennCare as encounter data. As of March 2019, Tennessee Carriers, Inc., the non-emergency subcontractor, agreed to submit all denied service lines as encounter data to the Division of TennCare.

Management Comments

AGP concurs. Both AGP's vision subcontractor and non-emergency transportation subcontractor have been submitting all denied claims per the agreements noted in TDCI's above findings in Section VI.D.2.b.

c. Eligibility Issue:

For the November 2018 focused claims testing, Tennessee Carriers, Inc., the non-emergency transportation subcontractor, indicated four claims were incorrectly denied as “not eligible”. Tennessee Carriers stated that while the members were eligible on the dates of service, the system incorrectly processed these claims. AGP responded that Tennessee Carriers, Inc. has transitioned to a new platform for claims processing which has better capabilities at preventing this type of error.

Management Comments

AGP concurs. While the four (4) referenced claims were denied correctly, the denial reason was incorrectly indicated as member "not eligible". No over or underpayment occurred with these claims. These four (4) claims are part of the ten (10) claims discussed above in Section VI.A that were erroneously reported as eligibility denials. Member eligibility was not a factor in the denial of these claims. As noted above in TDCI's finding in Section VI.D.2.c, Tennessee Carriers Inc. has implemented a new platform that greatly reduces the potential for the root cause of this issue to occur going forward.

3. Verification by TDCI of Focused Claims Testing Results

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

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

- TDCI judgmentally selected 59 claims for testing in which AGP reported errors.

All 59 claims reported by AGP with processing errors were properly reprocessed by AGP. The following deficiencies were noted by TDCI during the reverification testing of 48 claims in which AGP reported no errors during their focused claims testing results:

- For five denied claims selected by TDCI for verification, AGP incorrectly responded to TDCI for the focused testing attribute “Denial Reasons Communicated to Provider Appropriately”. Three of the five claims were incorrectly denied with the reason code “pre-auth not obtained” since prior authorization for service was obtained or was not required. One claim was incorrectly denied with the reason code “Disallow-not allowed under contract” since the service was allowed under the provider contract with AGP. One claim was incorrectly denied with the denial reason code “The Provider is a Primary Care Provider who was not the member’s assigned Primary Care Provider” since the provider was assigned as the member’s primary care provider.

- For two paid claims selected by TDCI for verification, AGP incorrectly responded to TDCI for the focused testing attribute “Payment Agrees to Provider Contracted Rate.” The amounts paid for these two claims did not agree with the provider’s contracted rate.

  Management Comments

  AGP concurs. All noted claims have now been reprocessed. Additionally, AGP has included an additional layer of review for TDCI Focused Claims Testing. First, AGP's Claims Quality Assurance Team now reviews TDCI focus review test claims and returns to AGP's Operations Team for a secondary review. Training sessions on the proper review of claims and proper assignment of attributes were conducted with all teams involved in the review of TDCI test claims. A written desktop was also created on steps to be taken when responding to the monthly TDCI focus claims reviews.

E. Copayment Testing

The purpose of copayment testing is 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, 2018. From the listing, five enrollees were judgmentally selected and all of the claims processed for those enrollees in calendar year 2018 were analyzed to determine if AGP had correctly applied copayment requirements of the CRA based upon the enrollees eligibility status. No errors were noted by TDCI during the application of copayments testing.

F. Remittance Advice Testing

The purpose of remittance advice testing is 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 is to: (1) verify the actual payment of claims by AGP; and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

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

H. Pended and Unpaid Claims Testing

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

The pended and unpaid data files submitted to TDCI as of June 30, 2019 were reviewed for claims which were unprocessed and exceeded 60 days from the receipt date. The pended and unpaid data file of claims unprocessed by AGP, as well as subcontractors, indicate a total of 11,402 claims exceeding 60 days in process. Total first submission claims processed by AGP for June 2019 was 617,590. No material liability exists for claims over 60 days.

I. Mailroom and Claims Inventory Controls

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

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

- Responses to internal control questionnaires regarding mailroom operations were reviewed,

- Staff of each mailroom were interviewed, and
- Flowcharts documenting mailroom processes were reviewed.

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

VII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints Received by AGP

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

> The health maintenance organization must respond to the reconsideration request within thirty (30) calendar days after receipt of the request. The response may be a letter acknowledging the receipt of the reconsideration request with an estimated time frame in which the health maintenance organization will complete its investigation and provide a complete response to the provider. If the health maintenance organization determines that it needs longer than thirty (30) calendar days to completely respond to the provider, the health maintenance organization's reconsideration decision shall be issued within sixty (60) calendar days after receipt of the reconsideration request, unless a longer time to completely respond is agreed upon in writing by the provider and the health maintenance organization.

TDCI utilized the December 2018 provider appeal logs to verify the timeliness of provider reconsideration requests. Initial review of the log noted that for 30 of the 4,965 provider reconsideration requests received, AGP did not enter the provider reconsideration requests into the log for more than 30 days after being received from the provider. Since no action was taken on these 30 provider reconsideration requests within 30 days, AGP failed the timeliness standard for reconsideration requests set forth in Tenn. Code Ann. § 56-32-126(b)(2)(A).

Management Comments

AGP concurs. The deficiencies noted are mainly due to provider claim disputes being initially identified incorrectly during intake and being misrouted as correspondence causing AGP to miss response letter timeframes. Effective September 2019, AGP's Tennessee Correspondence work items have moved out of the division previously handling all AGP markets and been assigned to a Tennessee New Day Claims Market Manager. This division responsibility change will allow for greater focus on Tennessee only provider claim disputes and will limit the risk of misidentification and response letter timeframes being missed. A second

contributing factor was caused by a system upgrade issue where automated 30-day response letters did not generate. A system update has now been made to address this issue. Additionally, the Tennessee New Day Claims Market Manager now receives a daily monitoring report to ensure the 30-day response letter is being sent timely. Last, AGP's provider complaint report monitoring has been modified to first-in/first-out aging priority.

Additionally, TDCI judgmentally selected twenty-five (25) provider complaints from the December 2018 AGP provider appeal log for review. The selection criteria included provider complaints with processing lags of less than 30 days, between 30 and 60 days and greater than 60 days.

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

- Seven of the 25 complaints selected were not resolved within 30 days of receipt and AGP failed to inform the provider that a decision would be made within 60 days of receipt.

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

Management Comments

AGP concurs. The deficiencies noted are mainly due to provider claim disputes being initially identified incorrectly during intake and being misrouted as correspondence causing AGP to miss response letter timeframes. Effective September 2019, AGP's Tennessee Correspondence work items have moved out of the division previously handling all AGP markets and been assigned to a Tennessee New Day Claims Market Manager. This division responsibility change will allow for greater focus on Tennessee only provider claim disputes and will limit the risk of misidentification and response letter timeframes being missed. Additionally, with respect to the written provider agreement and acknowledgement requirement for provider complaints not resolved in sixty (60) days, AGP has moved up its timing for starting outreach to affected providers from *Day 53 after receipt of a provider complaint* to *Day 43 after receipt of a provider complaint* in order to give AGP more time to obtain written provider agreement as some providers may have to be contacted several times.

B. Provider Complaints Received by TDCI

TDCI offers to providers a complaint process for disputes with TennCare MCOs. Complaints may involve claims payment accuracy and timeliness, credentialing procedures, inability to contact or obtain assistance from the MCO, miscommunication or confusion around MCO policy and procedures, etc. When a

provider complaint is received, TDCI forwards the complaint to the MCO for investigation. The MCO is required to respond in writing within 30 calendar days to both the provider and TDCI to avoid assessment of liquidated damages pursuant to the "On Request" report requirements of the CRA.

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

For the period January 1 through December 31, 2018, TDCI received and processed 422 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	190
Previous denial or payment upheld	188
Previous denial or underpayment partially reversed in favor of the provider	3
Paid by AGP upon receipt of complaint	5
Other inquiries	21
Ineligible or duplicate complaint	15

TDCI judgmentally selected 24 of these provider complaints for review. The issues raised by the providers were analyzed and questions were posed to AGP for response. Emphasis was placed on discovering deficiencies in the AGP's claims processing system or provider complaint procedures. The following deficiencies were noted during the review of AGP's complaint review processes:

- For two of the 24 provider complaints selected, TDCI noted that AGP did not correctly review the provide complaint and provide a sufficient first response to TDCI. For one claim, AGP upheld its decision on the processing of a hospice claim. After second review request by TDCI, AGP determined an incorrect rate had been applied to the claim. For one claim, AGP determined it had incorrectly paid another TennCare MCO instead of the provider. The provider informed TDCI that AGP was not responding to inquiries regarding payment. AGP reprocessed and paid the provider after follow-up by TDCI.

  Management Comment

  AGP concurs. AGP has updated its processing instructions as well as its systems to ensure provider complaints are worked appropriately and timely. AGP has also educated its associates on utilizing the appropriate policies and processes that were implemented for provider complaints.

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, 2018, 110 independent reviews were initiated by providers against AGP. The following is a summary of the reviewer decisions:

Reviewer decision in favor of AGP	24
Reviewer decision in favor of the provider	17
Settled for the provider prior to reviewer decision	14
Settled partially for the provider and AGP prior to reviewer decision	1
Previous denial or underpayment partially reversed in favor of the provider	18
Ineligible for independent review	29
Rescinded by provider	7

TDCI judgmentally selected five independent reviews for testing. The issues raised by the providers were analyzed and questions were posed to AGP for response. Emphasis was placed on discovering deficiencies in the AGP's claims processing system or provider complaint and appeal procedures. The following deficiencies were noted during the review of AGP independent review processes:

- For three of the 5 independent reviews selected, TDCI noted that AGP did not correctly review the providers' requests for reconsideration which resulted in the disputes being submitted for independent review. AGP reversed the previous denials and paid the claims after the independent review requests were filed.

- An independent review decision was made in favor of the provider on April 16, 2018. AGP did not pay the provider based on the independent review decision until April 4, 2019. Per TCA 56-32-126b(3), once a reviewer has made a decision requiring the HMO to make payment, the HMO must send payment within 20 days of the date of the reviewer's decision.

Management Comments

AGP concurs. AGP has updated its processing instructions as well as its systems to ensure Independent Reviews are worked appropriately and timely. AGP has also educated its associates on utilizing the appropriate policies and processes that were implemented for Independent Reviews.

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. AGP routinely submits updates to the provider manual to TDCI for prior approval. An update of the provider manual was approved by TDCI on May 3, 2019.

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 Division of TennCare has defined through contract with the HMO minimum language requirements to be contained in the agreement between the HMO and providers. These minimum contract language requirements include, but are not limited to: standards of care, assurance of TennCare enrollees' rights, compliance with all federal and state laws and regulations, and prompt and accurate payment from the HMO to the provider.

Per Section A.2.12.2 of the CRA, all template provider agreements and revisions thereto must be approved in advance by TDCI, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Additionally, Section A.2.12.7 of the CRA reports the minimum language requirements for provider agreements. Section A.2.12.9.48 further states that for modifications that do not require amendments to be valid only when reduced to writing, duly signed and attached to the original of the provider agreement, the terms shall include provisions allowing at least thirty (30) calendar days for providers to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., certified mail, facsimile, hand-delivered receipt, etc.)

A total of 35 executed provider agreements were requested from the no error claims selected for focused testing in section VI.D. of this examination report. The provider agreements selected included five executed by the transportation subcontractor, Tennessee Carriers, Inc. and five executed by the vision subcontractor, Eyequest.

The following deficiencies were noted in 35 provider agreements selected for testing:

- Two of the 35 executed provider agreements provided and tested were not on templates that were approved by TDCI.

- Ten of the 35 provider agreements selected for testing did not contain the most current TennCare regulatory appendix and regulatory language that incorporates CRA amendments 4 and 5.

Management Comments

AGP concurs. With respect to the two (2) executed provider agreements that were not on templates approved by TDCI, this was an isolated incident as a result of a clerical error where the AGP processor of the contracts did not submit the custom base agreement through the established regulatory review and approval process. With respect to the ten (10) provider agreements that were found to be non-compliant with the most current TennCare regulatory language for CRA amendments 4 and 5, AGP completed a mass Amendment-By-Notification (ABN) provider agreement update project in 2017 to incorporate the required regulatory language for CRA Amendments 4 and 5. However, these 10 provider agreements were on custom templates and could not be updated through the mass ABN update project. To address the gap with respect to these 10 agreements, AGP will be updating its Medicaid Provider Manual to incorporate AGP's Medicaid Regulatory Addendum as the Addendum contains the required regulatory language from CRA amendments 4 and 5.

AGP will revise its Medicaid Provider Manual with the incorporated AGP Medicaid Regulatory Addendum by no later December 31, 2019.

F. Provider Payments

Capitation payments made to providers during 2018 were tested to determine if AGP complied with the payment provisions set forth in its capitated provider agreements. Review of payments to capitated providers indicated that all payments were made per the provider contract requirements.

G. Subcontracts

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

Five subcontract agreements were judgmentally selected and tested to determine the following: (1) that the subcontract templates were prior approved by TDCI and the Division of TennCare and (2) that the executed agreements were on approved templates. The following deficiency was noted in the testing of subcontracts:

- Two of the five executed subcontracts selected for testing have never been submitted to TDCI and the Division of TennCare for prior approval. The unapproved subcontracts were with OptumInsight, which performs COB, subrogation, overpayment data mining, and credit balance recoveries services, and Cotiviti, which performs overpayment data mining and hospital bill audits.

Management Comments

AGP concurs. AGP acknowledges 2 of the 5 subcontracts were not filed with TDCI upon revision to the original subcontract approval. The two (2) subcontracts in question are:

- Cotiviti, which performs overpayment data mining and hospital bill audits, and
- OptumInsight, which performs COB, Subrogation, overpayment data mining, and credit balance recoveries services

AGP is finalizing negotiations of updated agreements with both Cotiviti and OptumInsight. AGP will submit the agreements for TDCI review and approval by no later than December 31, 2019.

H. Subcontractor Monitoring

The CRA between AGP and the Division of TennCare allows AGP to delegate activities to a subcontractor. AGP is required to reduce subcontractor agreements to writing and specify the activities and report responsibilities delegated to the subcontractor. AGP should monitor the subcontractor's performance on an ongoing basis. Also, AGP should identify any deficiencies or areas for improvement and determine the appropriate corrective action as necessary. Section A.2.26.1 of the CRA states that if the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6." Additionally, Section A.2.26.8 requires AGP to ensure that subcontractors comply with all applicable requirements of the CRA. Federal and state requirements include, but are not limited to, specific regulations regarding non-discrimination, conflicts of interest, lobbying, and offer of gratuities.

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

I. Non-discrimination

Section A.2.28.2 of the CRA requires AGP to demonstrate compliance with the applicable state and federal civil rights laws, guidance, and policies. including Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, the Age of Discrimination Act of 1975 and the Church Amendments (42 U.S.C. 300a-7), Section 245 of the Public Health Service Act (42 U.S.C. 238n.), and the Weldon Amendment (Consolidated Appropriations Act 2008, Public Law 110-161, Div. G, Sec. 508(d)m 121 Stat. 1844, 2209). Based on discussions with various AGP staff and a review of policies and related supporting documentation, AGP was in compliance with the reporting requirements of Section A.2.28.2 of the CRA.

J. Internal Audit Function

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

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

K. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., Title 56, Chapter 11, Part 1 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-105 requires 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 to 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 2019 for the calendar year 2018.

L. Health Insurance Portability and Accountability Act (HIPAA)

Section A.2.27 of the CRA requires AGP to comply with requirements of the Health Insurance Portability and Accountability Act of 1996 and Health Information Technology for Economic and Clinical Health (HITECH) under the American Recovery and Reinvestment Act of 2009, including but not limited to, the transactions and code set, privacy, security, and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data partner situations required under the regulations.

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

M. Conflict of Interest

Section E.28 of the CRA warrants that no part of the amount provided by TennCare shall be paid directly, indirectly or through a parent organization, subsidiary or an affiliate organization to any state of federal officer or employee of the State of Tennessee or any immediate family member of a state of federal officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to AGP in connection with any work contemplated or performed relative to the CRA 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.

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

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

N. Episodes of Care Testing

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

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

thresholds. PAPs that achieve the commendable cost threshold are rewarded for their high performance in the previous year. PAPs that exceed the acceptable cost threshold are assessed a financial penalty for a share of the amount of costs that were over and above all their peers. A more detailed explanation of episode of care initiative can be found at https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html.

Beginning with the provider reports issued in August 2016, TDCI, at the request of the Division of TennCare, began quarterly testing the accuracy of the reports prepared by the MCOs. From listings of all enrollee episodes for each quarter, TDCI randomly selected a sample of 25 enrollee episodes included in the PAP's average cost calculations and requested from the plan supporting provider reports, claims data files, and risk marker supporting files. The provider reports were vouched to supporting claims in the claims data files. Utilizing the design dimensions for each episode-based model, TDCI applied inclusion and exclusion criteria to the claims data files including, but not limited to, the following:

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

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

TDCI selected for testing a total of 100 enrollee included episodes from final and interim reports issued by AGP from February 2018 through November 2018. Also, TDCI selected for testing 120 enrollee episodes excluded from the PAP's average cost calculations. The following table reports the results of testing by episode of care from final and interim reports issued by AGP from February 2018 through November 2018.

Results of Episodes of Care Testing

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

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, 2016:

A. Financial Deficiencies

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

B. Claims Processing Deficiencies

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

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

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

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

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

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

- For the February 2016 focused claims testing, AGP indicated four claims were incorrectly denied with reason code “G72 – No MCD#/Disclosure Form”. AGP stated the disclosure form was received August 13, 2015, but the form was not properly loaded in the claims processing system.

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

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

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

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

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

7. TDCI reviewed 54 claims reported by AGP as being processed incorrectly during focused claims testing for the calendar year 2016. TDCI noted that two of the 54 claims that AGP reported as inaccurately processed were not corrected by AGP as of fieldwork during June 2017.

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

Findings one through six have been repeated in the current examination.

C. Compliance Deficiencies

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

   - Nine of the 25 complaints selected for testing were not resolved within 30 days and AGP failed to inform the provider that a decision would be made within 60 days of receipt.
   - Five of the 25 provider complaints selected for testing were not resolved within 60 days and no written agreement with the provider was executed to allow for additional time to resolve the complaint.

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

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

   - Two of the five executed subcontracts selected for testing have never been submitted to TDCI and the Division of TennCare for prior approval.
   - For one of the five subcontracts selected for testing, Amerigroup determined that filing the subcontract with the TDCI and the Division of TennCare was not necessary. The subcontract should have been prior approved by the Division of TennCare and TDCI.

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

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

5. During the testing of episodes of care reports for calendar year 2016, TDCI noted an error in the improper identification and application of a risk marker for an enrollee. The provider report indicated risk adjusted cost for this enrollee of $10,526 which is understated by $547.14 or 5.2%.

Findings one, two and three have been repeated in the current examination.