



STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

and

FINANCIAL AND COMPLIANCE EXAMINATION

OF

THE TENNCARE OPERATIONS

OF

AMERIGROUP TENNESSEE, INC.

NASHVILLE, TENNESSEE

FOR THE PERIOD JANUARY 1, 2020
THROUGH DECEMBER 31, 2020

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DATE: February 8, 2022

The Financial and Compliance Examination and Market Conduct Examination of the TennCare Operations of AMERIGROUP Tennessee Inc., Nashville, Tennessee, was completed October 17, 2021. The report of this examination is herein respectfully submitted.

I. FOREWORD

On April 10, 2020, 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 September 1, 2021 and ended on October 19, 2021. All document requests and the signed management representation letter were provided by October 19, 2021.

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, 2020.

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, 2020, were as follows:

Officers for AGP

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

Other Officers for AGP

Vincent Edward Scher, Treasurer
Eric (Rick) Kenneth Noble, Assistant Treasurer

Directors or Trustees for AGP

Kristen Louise Metzger
Robert Thomas Garnett
Jack Louis Young

B. Brief Overview

Since April 1, 2007, AGP has been 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, 2020, AGP had approximately 451,000 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, 2020, AGP had approximately 8,400 enrollees assigned to the CHOICES program.

Effective July 1, 2016, AGP began offering services through the Employment and Community First CHOICES program. ECF CHOICES is a program for people of all ages who have an intellectual or developmental disability (I/DD). Services in the 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, 2020, AGP had 754 enrollees in the Employment and Community First CHOICES program.

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, which is a product of DentaQuest USA Insurance Company, Inc., 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

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

B. Claims Processing Deficiencies

1. 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 February 2020.

(See Section VI.A. of this report)

2. Prompt pay testing determined that ECF CHOICES HCBS claims were not processed in compliance with Section A.2.22.4 of the CRA for February, March, April, May, October, November, and December of 2020.

(See Section VI.A. of this report)

3. AGP failed to achieve claims payment accuracy requirements of 97% per Section A.2.22.6 of the CRA for:

- CHOICES HCBS in January 2020 for East, Middle, and West Regions.
- ECF CHOICES HCBS in March 2020 for the Middle Region.
- Nursing Facilities in July 2020 for the West Region and in August 2020 for East, Middle, and West Regions.

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

4. During the review of AGP's December 2020 claims payment accuracy report, TDCI noted that one of the fifteen claims selected for testing was paid in error. The claim should have been paid by the member's other insurance before the claim was paid by TennCare.

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

5. 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 2020, AGP reported at least one attribute error on 103 claims during focused claims testing.

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

6. During the review of focused claims testing results, TDCI noted seven additional claims processing deficiencies that resulted in the reprocessing of 21,313 claims with billed charges of \$3,183,850. Details of the additional deficiencies are described in this report.

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

7. The following deficiencies were noted by TDCI during the reverification testing of 45 claims in which AGP reported no errors during their focused claims testing results:

- For one claim selected by TDCI for reverification, AGP incorrectly denied claim lines with the explanation code "Primary Carrier denied the procedure code/bill type is inconsistent with the place of service."
- For one claim selected by TDCI for reverification, AGP incorrectly denied claims lines with the explanation code "Deny preauth not obtained."

(See Section VI.D.3.1. of this report)

8. The follow deficiency was noted by TDCI during the reverification testing of 36 claims in which AGP reported errors during their focused claims testing results. One error claim was not properly reprocessed by AGP. As a result, AGP incorrectly paid for 2 home delivered meals on the same date of service.

(See Section VI.D.3.2. of this report)

9. For two of the five enrollees selected for copayment testing, AGP failed to properly apply copay requirements based on the enrollee's eligibility status.

(See Section VI.E)

C. Compliance Deficiencies

1. For the test month of December 2020, the following deficiencies were noted in review of AGP's claim processing provider complaint log:

- Two of the 15 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.
- Eight of the 15 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.

(See Section VII.A. of this report)

2. For six of the 20 provider complaints submitted to TDCI for review, AGP's claims appeal procedures failed to properly determine the claims had been incorrectly denied.

(See Section VII.B. of this report)

3. For one of the provider agreements selected for testing, AGP submitted and TDCI approved an agreement specific to two providers. After the initial approval by TDCI, the provider agreement was altered to include an additional provider before execution. The amended agreement was not resubmitted to TDCI for approval.

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

4. AGP's subcontractors, Tennessee Carriers, Inc., and Eyequest, failed to obtain written approval in advance from the Division of TennCare for customer service call centers subcontracts. Additionally, the subcontracts were not submitted to TDCI for 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, 2020, AGP reported \$939,968,616 in admitted assets, \$646,433,527 in liabilities and \$293,535,089 in capital and surplus on the 2020 Annual Statement submitted March 1, 2021. AGP reported total net income of \$54,441,355 on the statement of revenue and expenses. The 2020 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, 2020. 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, 2020, 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, 2020:

Reported Capital and Surplus	\$293,535,089
Reported Authorized Control Level Risk-Based Capital	\$61,243,666
Computed Company Action Level Risk-Based Capital (300% of Authorized Control Level)	\$183,730,998

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, 2020, 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, 2020, 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, 2020.

- (1) For the period ending December 31, 2020, AGP reported total company premium revenues of \$1,915,780,434 on the 2020 NAIC Annual Statement (Schedule T total).
- (2) For the period ending December 31, 2020, AGP reported total payments from the Division of TennCare of \$2,329,459,988 (TennCare cash-excluding PBM), and all other premiums and consideration of \$1,935,480 (Schedule T total minus TN Medicaid), for a total of \$2,331,395,468.

Utilizing \$2,331,395,468 as the premium revenue base, AGP's minimum net worth requirement as of December 31, 2020 is \$38,720,932 ($\$150,000,000 \times 4\% + (\$2,331,395,468 - 150,000,000) \times 1.5\%$). AGP's reported net worth at December 31, 2020, was \$254,814,157 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 \$2,331,395,468. AGP's calculated restricted deposit requirement as of December 31, 2020 is \$12,900,000. As of December 31, 2020, 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 \$193,879,529 claims unpaid as of December 31, 2020. The reported amount was certified by a statement of actuarial opinion.

Analysis by TDCI of the triangle lag payment reports through June 30, 2021 for dates of services before January 1, 2021, and review of subsequent NAIC financial filings determined that the reported claims payable for TennCare operations was overstated. Additionally, on the Health Quarterly Statement as of June 30, 2021, the following was noted by AGP:

- "The estimated cost of claims and claim adjustment expense attributable to insured events of prior year's decreased by \$29,086,518 during 2021."
- "The redundancy reflects the decreases in estimated claims and claims adjustment expenses as a result of claims payment during the year, and as additional information is received regarding claims incurred prior to 2021. Recent claims development trends are also taken into account in evaluating the overall adequacy of unpaid claims and unpaid claims adjustment expense. "

TDCI does not propose an adjustment to capital and surplus for December 31, 2020. AGP has made the necessary correction of this estimate in calendar year 2021.

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, 2020, AGP's TennCare Operating Statement reported Total Revenues of \$1,926,292,753, Medical Expenses of \$1,533,382,905, Administrative Expenses of \$307,487,294, Income Tax Expense of \$30,936,847 and Net Income of \$54,485,707.

No reportable deficiencies were noted in the preparation of the TennCare Operating Statements for the period ending December 31, 2020. The TennCare Operating Statements are separate schedules in the AGP 2020 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, 2020, through December 31, 2020, were submitted January 20, 2021. Based on TDCI's analysis, the combined medical loss ratio with capitation revenue net of premium tax was 93.43% for this period. AGP's June 2021 MLRs were submitted on July 20, 2021. Based on an analysis of AGP's June 2021 MLRs for the period July 1, 2020 through

December 31, 2020, the combined medical loss ratio was 91.84%. 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 payments of actual claims.

D. Administrative Expenses and Management Agreement

For the year ended December 31, 2020, AGP reported total Administrative Expenses of \$308,160,940 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 16.1% of total premium revenue.

Effective January 1, 2014, the company entered into an administrative services agreement with its affiliated companies which the Department approved on February 20, 2014. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The costs and expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Direct costs include expenses such as salaries, employee benefits, communications, advertising, consulting services, maintenance, rent utilities, and supplies which are directly attributable to the Company's operations. Allocated costs include expenses such as salaries, benefit claims and enrollment processing, billings, accounting, underwriting, product development and budgeting, which support the Company's operations. These costs are allocated based on various utilization statistics. The 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, 2020, management fees/allocated expenses of \$171,698,019 were charged to AGP by Anthem Inc. The management fee represented approximately 9% 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.

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 2020	100%	100%	Yes
February 2020	100%	99.8%	Yes
March 2020	100%	99.9%	Yes
April 2020	99%	99.9%	Yes
May 2020	99%	100.0%	Yes
June 2020	99%	99.8%	Yes
July 2020	98%	99.8%	Yes
August 2020	100%	100%	Yes
September 2020	100%	100%	Yes
October 2020	99%	99.8%	Yes
November 2020	99%	99.6%	Yes
December 2020	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 2020.

Prompt Pay Results for Vision

Prompt pay testing determined that vision claims processed by the vision subcontractor, EyeQuest, Inc., were in compliance with Section A.2.22.4 of the CRA and Tenn. Code Ann. § 56-126(b)(1) for all months in calendar year 2020.

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 2020.

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 in February 2020 only 98.8% of nursing facility and CHOICES HCBS claims were processed within 21 calendar days of receipt which is not in compliance with Section A.2.22.4 of the CRA.

AGP submitted to TDCI a corrective action plan for non-compliance with Section A.2.22.4 of the CRA for the month of February 2020. The corrective action plan indicated that claims were not paid within the 21-day prompt pay metric due to a production change on January 15, 2020, that caused 154,725 Tennessee claims to misprice over a period of six days. Amerigroup pended claims until this issue was resolved resulting in delays in processing claims timely in the month of February 2020. AGP reversed the production change and reprocessed effected claims.

Management Comments

Management concurs. The issue has not occurred again as all gaps in controls were identified and corrected in 2020.

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 2020	98%	99.9%	Yes
February 2020	86%	93.4%	No
March 2020	90%	92.7%	No
April 2020	81%	99.8%	No
May 2020	73%	94.6%	No
June 2020	100%	100.0%	Yes
July 2020	100%	100.0%	Yes
August 2020	99%	99.7%	Yes
September 2020	94%	100.0%	Yes
October 2020	98%	98.4%	No
November 2020	93%	99.3%	No
December 2020	86%	100%	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 seven months in calendar year 2020.

AGP submitted to TDCI corrective action plans for non-compliance with Section A.2.22.4 of the CRA for each month determined non-compliant. The corrective action plan indicated that claims were not paid within the 14 and/or 21-day prompt pay metric due to incorrect system edits, inadequate policies and procedures, and personal availability and training. AGP rolled back the system edits, updated policies, and procedures to account for the prompt pay requirements, added additional claims analysts, and provided additional training to the analyst team.

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 \$50,000 in liquidated damages against AGP.

Management Comments

Management concurs. In addition to the corrective action plan elements, Amerigroup's Claims processing team has increased the tracking and monitoring of pending claims that require provider updates. Additional staff were added to support the shorter claims processing time. The team has also instituted daily reminders and additional support to the staff processing these claims.

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, thirty (30) claims associated with ECF CHOICES HCBS provided to ECF 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 2020 for the following regions, months, and claim types:

Month of Filing	Claim Type	Region	Percentage Reported
January 2020	HCBS	East	93.2%
January 2020	HCBS	Middle	93.2%
January 2020	HCBS	West	93.2%
March 2020	ECF CHOICES HCBS	Middle	93.0%
July 2020	Nursing Facility	West	95.0%
August 2020	Nursing Facility	East	95.0%
August 2020	Nursing Facility	Middle	95.0%
August 2020	Nursing Facility	West	95.0%

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 \$40,000 in liquidated damages during 2020 related to claims payment accuracy failures.

Management Comments

Management concurs. As outlined in corrective action plans, Amerigroup removed the inappropriate system edits impacting claims in January and March 2020. The edit issue has not occurred again as all gaps in controls were identified and corrected in 2020. For July 2020, a COVID waiver message and documentation was updated. To address claims processing errors related to patient liability, Amerigroup's Claims processing team decreased the number of staff working on the claim types that handle patient liability. Using seasoned staff with more experience has helped lower the risk. Daily reminders to staff to ensure they check patient liability calculations along with encouragement to staff and rewarding good behaviors are additional tools used.

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 the audit and reported compliance with monthly claims payment accuracy requirements for all months in calendar year 2020.

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 2020, TDCI judgmentally selected for verification fifteen claims (10 Medical and 5 NEMT) reported as accurately processed. TDCI tested these claims to the attributes required in Section A.2.22.6.4 of the CRA. For one of the fifteen claims TDCI tested, TDCI noted that the claim was paid in error. The claim should have been paid by the member's other insurance before the claim was paid by TennCare. (NEMT Claim # 622352504)

Management Comments

Management concurs. Tennessee Carriers, Inc. has implemented a dual eligibility review process to ensure Medicare benefits are exhausted before the Medicaid funding source is billed.

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 2020, 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 2020 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 2020, AGP reported at least one attribute error on 103 claims. It should be noted a claim may fail more than one attribute. For the 103 claims, 167 attribute errors were reported by AGP. The following table summarizes the focused claims testing errors reported by AGP for the calendar year 2020:

Attribute Tested	Errors Reported by AGP
Denial Reason Communicated to Provider Appropriate	102
Other Insurance Properly Considered	33
Authorization Requirements Properly Considered	18
Payment Agrees to Provider Contracted Rate	11
Modifier Codes Correctly Considered	1
Member Eligibility Correctly Considered	1
Correct Provider is Associated to Claim	1
Total	167

For the 103 claims that contained attribute errors, AGP identified 41 that were the result of claims processing system errors and 62 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

Management 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 represents the significant additional items noted by TDCI during monthly focused testing for calendar year 2020:

- a. For the January 2020 focused claims testing, AGP indicated there was a claims processing system error due to two providers having the same National Provider Identifier (NPI) and Taxpayer Identification Number (TIN) which caused the front end edit to select the incorrect provider identification. As a result, claims were denied in error. A project to correct the system error was completed on February 5, 2020, which

resulted in the reprocessing 3,789 claims with billed charges of \$133,249. To prevent this error in the future, AGP stated, “the logic has been modified to refer to the name and address instead of using NPI/TIN when choosing the provider ID”.

- b. For the February 2020, AGP indicated there was a manual error that erroneously denied claims with the explanation code “G04-Inappropriate Billing for this contract.” AGP stated, “The claim analyst did not follow the proper processing guidelines for hospice routine care services. This error was found under several analysts.” A project to correct the manual errors was completed on April 25, 2020, resulting in the reprocessing of 148 claims with billed charges of \$285,415. To prevent this error in the future, AGP indicated that claims analysts were re-educated.
- c. For the April, May, June, and September 2020, AGP indicated a claims processing system error caused claims to inappropriately deny with the explanation code “QA0- Explanation of Benefits is needed from the Member’s Primary Carrier.” As of July 10, 2020, AGP indicated 3,059 claims with billed charges of \$1,362,730 were impacted by this error. Efforts by AGP to correct the effected claims caused additional errors since consideration of patient liability was not properly considered on reprocessing.

Corrective Action Plan Submitted by AGP:

Amerigroup implemented a project on 2/10/2020, to automate Other Health Insurance (OHI) noncovered services claim denials. This project was implemented to increase auto adjudication and decrease manual COB errors. Test cases were developed and tested, but the testing inadvertently missed the scenario of coordination of benefits (COB) exception rules. Amerigroup is documenting all COB exception rules to implement a long-term permanent solution whereby its claims system will be reconfigured with correct COB exception logic allowing OHI claims to adjudicate correctly. This reconfiguration is targeted for implementation by 12/01/2020. Amerigroup will continue to improve its testing procedures for future system configurations to prevent against the recurrence of this type of issue by fully identifying all business requirements before development and conducting business rule/code impact analysis to minimize or stop unintended downstream impacts.

Follow-up by TDCI during examination fieldwork noted that during calendar year 2021, AGP continues to search for inappropriately denied claims for QA0 denials. Results of the searches indicate that the incorrect denials have discontinued, and the issue has been determined to be resolved.

- d. For November 2020, one claim was improperly denied with the explanation codes “Submit medical records for review” and “Deny preauth not obtained.” AGP indicated the claims processing system was not configured to comply with the Division of TennCare’s COVID-19 guidance. A project to correct all effected claims was completed resulting in the reprocessing of 1,682 claims with billed charges of \$168,400. AGP indicated the system has been properly reconfigured.

- e. For November 2020, AGP indicated a claims processing system error caused a provider’s claims to incorrectly deny with the explanation code “G60- Incorrect CMS claim form was submitted”. Per AGP, this provider was out of network and the five claims should have denied, “Y40-no auth on file.” Additionally, AGP indicated the claims were denied incorrectly because the provider was attached to an OON facility agreement instead of a group agreement. AGP also indicated that an exception memo was received from the Division of TennCare to reprocess all previously denied Medication Assisted Therapy (MAT) claims submitted by this provider. A project to reprocess the incorrect denials with dates of service of June 1, 2020, or later was completed and resulted in the reprocessing of 5,190 claims with billed charges of \$563,574.

- f. For December 2020, AGP indicated the claims processing system was improperly configured resulting in claims submitted by a provider to incorrectly deny. A project to correct the incorrect denials was completed on February 10, 2021, resulting in the reprocessing of 4,153 claims with billed charges of \$336,643. AGP indicated the claims processing system has been properly reconfigured.

- g. For December 2020, AGP indicated a claims processing system error caused a provider’s claims to incorrectly deny by requiring an authorization for certain outpatient procedures. The claims system had not been updated to reflect the provider was in a contracted status as of July 1, 2020. Projects to correct the incorrect denials were completed on May 22, 2021, resulting in the reprocessing of 3,292 claims with billed

charges of \$333,839. AGP has updated the contract status for the provider in the claims processing system.

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 45 claims for testing in which no errors were reported by AGP, and
- TDCI judgmentally selected 36 claims for testing in which AGP reported errors.

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

- a. For the 45 claims in which AGP reported no errors during their focused claims testing results:
 - For one claim selected by TDCI for reverification, AGP incorrectly denied claim lines with the explanation code "Primary Carrier denied the procedure code/bill type is inconsistent with the place of service." The error was the result of a manual error by the claims adjudicator. No other claims were affected by this error.
 - For one claim selected by TDCI for reverification, AGP incorrectly denied claim service lines for one contracted provider with the explanation code "Deny preauth not obtained." A preauthorization was not required for the claim as well as other claims submitted by the provider. As of the end of fieldwork, AGP is in the process of determining the total number of claims effected by this error.

AGP should develop controls to ensure monthly testing procedures identify all claims adjudication errors.

Management Comments

Management concurs. Amerigroup's Health Plan Operations team now reviews all focused claims responses and submits claims reprocessing projects to capture all claims for all providers that may have been impacted by the error identified in the focused claims testing.

With respect to the second finding, Amerigroup determined there were 15,008 claims impacted. To date 6,379 claims have been reprocessed with a total payout of \$118,852.99. This reprocessing project will be completed on or before February 14, 2022.

- b. During the review of 36 claims in which AGP reported processing errors, one error claim was not properly reprocessed by AGP. As a result, AGP incorrectly paid for 2 home delivered meals on the same date of service. AGP should develop controls to ensure that claims identified as errors during the focused claims testing are properly reprocessed.

Management Comments

Management concurs. Amerigroup's Health Plan Operations team now reviews all identified errors in the focus claims testing to ensure reprocessing has occurred.

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, 2020. From the listing, five enrollees were judgmentally selected, and all of the claims processed for those enrollees in calendar year 2020 were analyzed to determine if AGP had correctly applied copayment requirements of the CRA based upon the enrollee's eligibility status. For two of the five enrollees selected for copayment testing, the following errors were discovered:

- AGP did not apply a copayment to an enrollee's claim for a telehealth office visit with a specialist. A \$20 copayment should have been applied to the enrollee's claim based upon the enrollee's eligibility status.
- AGP incorrectly applied a copayment of \$20 to an enrollee's claim for a PCP office visit. A \$15 copayment should have been applied to the enrollee's claim based upon the enrollee's eligibility status.

Management Comments

Management concurs.

For the first finding, the claims payment system was configured not to take the copayment for place of service 02 (telehealth). Amerigroup corrected the error in February 2021, but this claim was not identified in the claims reprocessing project. The claim was then reprocessed during the audit. Amerigroup commits to ensuring

our reprocessing project criteria is more detailed to avoid missing claims in future projects.

For the second finding, the provider is a nurse practitioner and therefore not set up as a PCP in the claims payment system. A complete review of all mid-level providers is underway to ensure that all mid-level providers acting as a PCP are updated in the claims processing system. This will allow the correct copays to be applied. The project will be completed on or before March 1, 2022. All claims affected will be reprocessed.

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 three cancelled checks or EFT documentation related to claims from the list of no error 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, 2021 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 15,217 claims exceeding 60 days in process. Total first submission claims processed by AGP for June 2021 was 764,514. 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, EyeQuest and Tennessee Carriers, Inc. during this examination; however, TDCI performed the following procedures to review mailroom and claims inventory controls:

- Responses to internal control questionnaires regarding mailroom operations were reviewed,
- Staff of each mailroom were interviewed,
- Current mailroom processes were reviewed to determine if incoming mail is properly inventoried and reconciled.
- 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, EyeQuest, 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 2020 provider appeal logs to verify the timeliness of provider reconsideration requests. TDCI judgmentally selected fifteen (15) provider complaints from the December 2020 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 fifteen (15) complaints selected:

- Two of the 15 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.
- Eight of the 15 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

Management concurs. For the 2 of the 15 complaints selected, Amerigroup cannot determine the root cause for the missing letters as we cannot recreate the error. We cannot determine if the letters were sent out, but a record was not maintained, or a system malfunction. Upon review of this process during the audit fieldwork, the letters were being generated correctly.

For the 8 of the 15 provider complaints, Amerigroup determined that the incorrect letter was sent to the provider, and it had no information to request their written agreement to the 60-day extension. The letters are being reconfigured to ensure the provider has the necessary information to provide written acknowledgement. The reconfiguration will be completed on or before March 1, 2022.

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, 2020, TDCI received and processed 267 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	153
Previous denial or payment upheld	84
Previous denial or underpayment partially reversed in favor of the provider	11
Paid by AGP upon receipt of complaint	3
Other inquiries	2
Ineligible or duplicate complaint	5
Resolved	6
Withdrawn	2
Enrollee Services Req (opened in Error)	1

TDCI judgmentally selected 20 of these provider complaints submitted to TDCI 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.

Deficiencies were noted during the review of AGP's provider complaint review processes. For six of the 20 provider complaints selected for testing, the provider first submitted the complaint to AGP as a claim appeal before submission to TDCI. After AGP upheld the denial on all six of the claim appeals, the provider submitted the claim appeals to TDCI as provider complaints. AGP overturned and paid the six claims in response to TDCI inquiries. Claim appeal procedures by AGP failed to properly determine the claims had been incorrectly denied.

Management Comments

Management concurs. Amerigroup's Reconsideration team (the individuals who handle claims appeals) had a management change in 2021. We have a new Manager in place and added additional staff. All staff members have been retrained in proper review procedures. We continue to reiterate the training through news blasts that stress the importance of following proper procedures (such as closely reviewing for attachments). As well, our Claims Management team that oversees the Reconsideration team has created a new workgroup to improve all processes related to claims processing; they will include claims appeals procedures in the workgroup for an end-to-end review.

C. Independent Reviews

The independent review process was established by Tenn. Code Ann. § 56-32-126(b)(2) to resolve claims disputes when a provider believes a TennCare MCO has partially or totally denied claims incorrectly. TDCI administers the independent review process but does not perform the independent review of the disputed claims. When a request for independent review is received, TDCI determines that the disputed claims are eligible for independent review based on the statutory

requirements (i.e. the disputed claims were submitted for independent review within 365 days from the date the MCO first denied the claims). If the claims are eligible, TDCI forwards the claims to a reviewer who is not a state employee or contractor and is independent of the MCO and the provider. The decision of the independent reviewer is binding unless either party to the dispute appeals the decision to any court having jurisdiction to review the independent reviewer's decision.

For the period January 1 through December 31, 2020, 52 independent reviews were initiated by providers against AGP. The following is a summary of the reviewer decisions:

Reviewer decision in favor of AGP	14
Reviewer decision in favor of the provider	12
Settled for the provider prior to reviewer decision	7
Settled partially for the provider and AGP prior to reviewer decision	2
Previous denial or underpayment partially reversed in favor of the provider	5
Ineligible for independent review	12

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. For the 5 independent reviews selected, no reportable issues were noted by TDCI in AGP's independent review processes.

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 January 15, 2021.

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 45 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 deficiency was noted in 45 provider agreements selected for testing:

For one of the provider agreements selected for testing, AGP submitted and TDCI prior approved an agreement specific to two providers. The provider agreement was altered to include an additional provider before execution, but the amended agreement was not resubmitted for TDCI approval.

Management Comments

Management concurs. Amerigroup has tighter controls in place today than in 2015 when this contract was executed. We have educated our provider contracting staff to ensure all entities are listed in an agreement before we submit for TDCI review and approval, and nothing can be amended in an approved agreement without another TDCI review and approval.

F. Provider Payments

Capitation payments made to providers during 2020 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 tested to determine the following: (1) the contract templates were prior approved by TDCI and the Division of TennCare, and (2) the executed agreements were on approved templates. No deficiencies were noted during the review of the five subcontracts selected for testing.

The following deficiencies were noted during the review of subcontractor operations. The AGP subcontractors, Tennessee Carriers, Inc., and Eyequest, have executed subcontracts for customer service call centers. Since the subcontracts utilize member protected health information, approval from Division of TennCare and TDCI is required. The subcontracts have not been approved in advance by the Division of TennCare. Also, the subcontracts were not submitted to TDCI for approval as material modifications.

Management Comments

Management concurs. Upon discovery of the agreements during the exam period, Amerigroup discussed with each subcontractor that any subcontracted arrangement must be disclosed to Amerigroup and agreements must be reviewed and approved by TDCI/Division of TennCare before execution. AGP will submit both vendors' agreements to TDCI on or before February 28, 2022.

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 2021 for the calendar year 2020.

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 or federal officer or employee of the State of Tennessee or any immediate family member of a state or federal officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to 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 2020 through November 2020. Also, TDCI selected for testing 100 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 2020 through November 2020.

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, 2018:

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.
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.

None of the financial deficiencies have been repeated in 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.
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.
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.
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.

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.
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.
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.
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.
 - 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.
 - 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.

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

Findings 2,3,5,6,7,8, and 9 have been repeated in the current examination.

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.
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.
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.

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.

Findings 1,2, and 4 have been repeated in the current examination.