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

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

d/b/a UnitedHealthCare Community Plan

NASHVILLE, TENNESSEE

FOR THE PERIOD JANUARY 1, 2017

THROUGH DECEMBER 31, 2017

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DATE: January 16, 2019

The Financial and Compliance Examination and Market Conduct Examination of the TennCare Operations of UnitedHealthcare Plan of the River Valley, Inc., Brentwood, Tennessee, was completed August 31, 2018. The report of this examination is herein respectfully submitted.

I. FOREWORD

On April 6, 2018, the TennCare Oversight Division of the Tennessee Department of Commerce and Insurance (TDCI) notified representatives of UnitedHealthcare Plan of the River Valley, Inc., (UPRV) d/b/a UnitedHealthcare Community Plan of its intention to perform a Financial and Compliance Examination and Market Conduct Examination of UPRV's TennCare Operations. Fieldwork began on August 13, 2018 and ended on August 31, 2018. All document requests and the signed management representation letter were provided by August 31, 2018.

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

UPRV 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, 2017.

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

The objectives of the examination were to:

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

III. PROFILE

A. Administrative Organization

UPRV is a wholly owned subsidiary of UnitedHealthcare Service Company of the River Valley, Inc. (USCRV). USCRV performs all administrative functions of UPRV through an administrative services agreement between UPRV and USCRV. USCRV is a wholly owned subsidiary of UnitedHealthcare, Inc. which in turn is a wholly owned subsidiary of United HealthCare Services, Inc. (UHS). UHS is a wholly owned subsidiary of UnitedHealth Group Inc. which is a publicly held company trading on the New York Stock Exchange.

In addition to TennCare operations, UPRV has Medicare and commercial lines of business in Tennessee, as well as health plans in three other states. UPRV is domiciled in Illinois.

The officers and directors or trustees for UPRV at December 31, 2017, were as follows:

Officers for UPRV

Robert Andersen Broomfield, President, Commercial
Robert Worth Oberrender, Treasurer
Christina Regina Palme-Krizak, Secretary
James Wesley Kelly, Chief Financial Officer
Nyle Brent Cottington, Vice President
Kimberly Grace Perry., Chief Medical Officer
Heather Anastasia Lang Jacobsen, Assistant Secretary

Directors or Trustees for UPRV

Cathie Sue Whiteside
William Kenneth Appelgate, PhD.
Yasmine Herminia Winkler
James Wesley Kelly
James Edward Hecker
Robert Andersen Broomfield
Scott Edward Williams

B. Brief Overview

UPRV has served TennCare enrollees in the East Tennessee Grand Region since the inception of the TennCare program in January 1994 under the CRA between UPRV, formerly John Deere Health Plan, and the Division of TennCare.

For the Middle Tennessee Grand Region effective April 1, 2007, the West Tennessee Grand Region effective November 1, 2008, and the East Tennessee Grand Region effective January 1, 2009, UPRV 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 UPRV and each enrollee's eligibility classification.

Also, in September 2017, UPRV began offering services through the Employment and Community First (ECF) CHOICES program. ECF 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, 2017, UPRV had approximately 456,600 TennCare members state-wide. The TennCare benefits required to be provided by UPRV during the examination period were:

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

For the period January 1, 2017, through December 31, 2017, UPRV received 47% of its nationwide revenue and 71% of its Tennessee revenue from payments for providing TennCare covered services to members.

In addition to TennCare operations, in January 2008, UPRV began offering a Medicare Advantage Special Needs Plan for those who are eligible for both Medicaid and Medicare. Also, effective January 2011, UPRV 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, 2017, UPRV had approximately 51,600 Medicare enrollees in in Tennessee.

C. Claims Processing Not Performed by UPRV

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

- March Vision Care Group, 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).

During the period under examination, UPRV arranged for the provision of supported housing services through contracts with Community Mental Health Centers (CMHCs) which have in turn subcontracted with individual supported housing providers.

Because the Division of TennCare has contracted with other organizations for the provision of dental and pharmacy benefits, UPRV 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. For one month in East Tennessee Region, UPRV failed to achieve claims payment accuracy requirements of 97% per Section A.2.22.6 of the CRA for medical claims.

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

2. For one month in East Tennessee Region, two months in Middle Tennessee Region, and one month in West Tennessee Region, UPRV failed to achieve claims payment accuracy requirements of 97% per Section A.2.22.6 of the CRA for nursing facilities claims.

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

3. For one month in West Tennessee Region, UPRV failed to achieve claims payment accuracy requirements of 97% per Section A.2.22.6 of the CRA for CHOICES Home and Community-based Services (HCBS) claims.

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

4. TDCI noted the following deficiencies during the review of UPRV's claims payment accuracy reports testing results for calendar year 2017:

   - Eight of the twenty-nine medical claims that UPRV tested and determined were inaccurately processed in December 2017 were not corrected by UPRV as of fieldwork during August 2018.

   - Two of the four vision claims that March Vision tested and determined were inaccurately processed in December 2017 were not corrected by March Vison as of field work in August 2018.

   - CRA Section A.2.22.6.4.5 states that the claim tests shall include verification that the allowed payment amount agrees with the contracted rate and the terms of the provider agreement. During TDCI's verification of March Vision's claims payment accuracy testing procedures, TDCI noted that March Vison does not trace the payment rate for the claims back to the executed provider agreement.

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

5. The CRA requires UPRV 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 2017, UPRV reported at least one attribute error on 184 claims during focused claims testing.

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

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

   - Multiple claims were inappropriately denied for authorization issues including improper entry of the authorizations, original authorizations deleted due to changes in members' eligibility and failure to follow proper procedures.

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

   - Twelve claims in calendar year 2017 were inappropriately denied for exceeding timely filing limits. The members were retroactively eligible, and the claims should have been paid.

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

   - For one claim in April 2017, UPRV noted a system error that inappropriately denied claims for no authorization where the provider is a contracted health department. As a result, all contracted health department claims were processed as out of network causing the claims to deny in error for no authorization. A total of 748 claims totaling $74,589 in billed charges were impacted by this error for this provider.

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

   - Four paid claims in three separate monthly focused testing were not successfully submitted to the Division of TennCare as encounter data because the claims failed the Division of TennCare's claims compliancy edit checks. Per Section A.2.23.4 of the CRA, UPRV's claims management system shall conform to HIPAA standard transaction code sets in order to submit encounter data to the Division of TennCare.

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

   - For one claim in November 2017, UPRV incorrectly denied the claim as duplicate because the system was not configured to differentiate between attending providers. The claim's dates, service codes, and modifiers matched another claim with the same dates, service codes, and modifiers. UPRV indicated that the error was a system error that impacted a total of 19 claims in the dollar amount of $980.49.

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

7. TDCI reviewed 47 claims reported by UPRV as being processed correctly during focused claims testing for the calendar year 2017. TDCI noted the following discrepancies:

   - During the review of the procedures utilized by UPRV when testing the attribute "Payment agrees to provider contracted rate", it was noted that UPRV does not verify the claim pricing accuracy with payment terms in the executed provider contract. UPRV cannot accurately test this attribute without comparing the payment to the contracted fee schedule.

   - For one claim in August 2017, TDCI noted that UPRV incorrectly paid a nursing facility claim that should have denied for spanning multiple months. UPRV failed to assess that the claim had been incorrectly processed in their response to focused testing. Additionally, TDCI noted two subsequent submissions with inclusive dates of service were also incorrectly paid because UPRV's duplicate processing logic failed to recognize the previous payment.

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

8. During the review of the 25 claims in which UPRV reported processing errors, TDCI noted one of the claims reported as an error during the 2017 focused claims test work was not corrected by UPRV as of the August 2018 fieldwork. UPRV should develop controls to ensure that claims identified as errors during the focused claims testing are corrected in a timely manner.

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

9. For five enrollees, all of the claims processed for those enrollees in calendar year 2017 were analyzed to determine if UPRV had correctly applied copayment requirements of the CRA based upon the enrollees' eligibility status. During the review, TDCI noted that UPRV incorrectly applied the copayment for two enrollees. The copayment amount for Community Mental Health services should have been $15, but UPRV applied a $5 copayment.

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

C. Compliance Deficiencies

1. TDCI reviewed sixteen provider complaints from the December 2017 UPRV claims processing department provider complaint log and noted that one complaint that took 199 days to resolve was not processed in accordance with Tenn. Code Ann. § 56-32-126(b)(2)(A).

   (See Section VII.A. of this report)

2. TDCI requested the executed provider agreements for the 47 claims tested above in Section VI.D.3. TDCI noted that 39 of the 47 provider agreements tested failed

to comply with Section A.2.12.9.48 of the CRA. The provider agreement regulatory appendix was updated through modifications to the provider manual; however, there was no evidence that the providers were given notice of the regulatory amendment through the provider manual update or that the providers were given 30 calendar days to give notice of rejection.

(See Section VII.E. of this report)

3. Five subcontract agreements were tested to determine if the contract templates were prior approved by TDCI and the Division of TennCare and if the executed agreements were on approved templates. The following discrepancies were noted:

   - One of the five executed subcontracts selected for testing had never been submitted to TDCI and the Division of TennCare for prior approval. Additionally, the subcontractor is a related party to UPRV. Tenn. Code Ann. § 56-11-106(a)(2) says, in part, that transactions involving an HMO and any person in its holding company system may not be entered into unless the HMO has notified the commissioner in writing of its intention to enter into the transaction at least thirty days prior. This agreement should have been filed as a Form D, Prior Notice of Transaction, due to the affiliated relationship.

   - UPRV has an approved subcontract with March Vision Care Group, Inc. for vision services management, payment of vision claims, and management of the vision network. However, March Vision Care Group, Inc., subcontracts management services with March Vision Care, Inc., an entity which is wholly owned by UnitedHealth Group, Inc. The subcontract between March Vision Care Group, Inc. and March Vision Care, Inc. has not been submitted to TDCI and the Division of TennCare for approval.

     (See Section VII.G. of this report)

4. In the 30 episodes selected for testing that were excluded from the Principal Accountable Providers' average cost calculations, one episode was incorrectly excluded as an episode where the episode trigger occurred in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC). UPRV was requested to identify the claim number and the Service Place or Type of Bill Code that identified the episode trigger as occurring in a FQHC or RHC. Optum, the subsidiary of UnitedHealth Group that processed the episode of care data for UPRV, responded that a correction was made post August processing to correctly include the episode. They determined that there was not a financial impact for the provider on gain or risk sharing.

   (See Section VII.N. of this report)

V. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, UPRV is required to file annual and quarterly financial statements in accordance with NAIC guidelines with the Tennessee Department of Commerce and Insurance. The department uses the information filed on these reports to determine if UPRV 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, 2017, UPRV reported $1,243,559,279 in admitted assets, $797,271,087 in liabilities and $446,288,192 in capital and surplus on the 2017 Annual Statement submitted March 1, 2018. UPRV reported total net income of $66,112,321 on the statement of revenue and expenses. The 2017 Annual Statement and other financial reports submitted by UPRV 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:

UPRV is required to comply with risk-based capital requirements for health organizations as codified in TCA § 56-46-201 et seq. On March 1, 2018, UPRV submitted a report of risk-based capital (RBC) levels which calculated estimated levels 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, 2017, UPRV maintains an excess of capital over the amount produced by the Company Action Level Events calculations required by TCA § 56-46-203. Additionally, UPRV'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 the December 31, 2017, reported capital and surplus to the Company Action Level requirements:

Reported Capital and Surplus	$ 446,288,192
Reported Authorized Control Level Risk-Based Capital	$ 110,732,140
Computed and Required Company Action Level Risk-Based Capital (200% of Authorized Control Level)	$ 221,464,280

b. HMO Net Worth Requirement:

Tenn. Code Ann. § 56-32-112(a)(2) requires UPRV 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 UPRV 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, 2017, 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, 2017, or (2) the total cash payments made to UPRV by the Division of TennCare plus premium revenue earned from non-TennCare operations for the period ending December 31, 2017.

(1) For the period ending December 31, 2017, UPRV reported total company premium revenues of $4,092,784,767, on the 2017 NAIC Annual Statement (Schedule T total).

(2) For the period ending December 31, 2017, UPRV received total payments from the Division of TennCare of $1,895,169,385 (TennCare cash-excluding PBM), and all other premiums and consideration of $2,158,912,780 (Schedule T total minus TN Medicaid T), for a total of $4,054,082,165.

Utilizing $4,092,784,767as the premium revenue base, UPRV's minimum net worth requirement as of December 31, 2017 is $65,141,772 ($150,000,000 x 4% + ($4,092,784,767-150,000,000) x 1.5%). UPRV's reported net worth at December 31, 2017, was $381,146,420 in excess of the required minimum reported.

2. Restricted Deposit

TCA § 56-32-112(b) sets forth the requirements for UPRV's restricted deposit. UPRV'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 $2,728,483,269. UPRV's calculated restricted deposit

requirement as of December 31, 2017, is $14,850,000. As of December 31, 2017, UPRV had on file with TDCI, a depository agreement and properly pledged safekeeping receipts totaling $37,000,000 to satisfy restricted deposit requirements.

3. Claims Payable

UPRV reported $486,456,294 claims unpaid as of December 31, 2017. Of the total claims unpaid reported, $180,340,689 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, 2018, for dates of services before January 1, 2018, and review of subsequent NAIC financial filings determined that the reported claims payable for TennCare operations was adequate.

B. TennCare Operating Statement

Sections A.2.30.16.3.3 and A.2.30.16.3.4 of the CRA require each submission of NAIC financial statements to contain a separate income statement detailing the quarterly and year-to-date revenues earned and expenses incurred as a result of participation in the TennCare program. For the year ended December 31, 2017, UPRV's TennCare Operating Statement reported Total Revenues of $1,936,453,222, Medical Expenses of $1,563,396,581, Administrative Expenses of $347,416,216, Income Tax Expense of $8,974,149, and Net Income of $16,666,276.

No reportable deficiencies were noted in the preparation of the TennCare Operating Statements for the period ending December 31, 2017. The TennCare Operating Statements are separate schedules in the UPRV 2017 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.

UPRV submits 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 the 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. UPRV's MLRs for the period July 1, 2017, through December 31, 2017, were submitted January 18, 2018. Based on TDCI's analysis, the combined medical loss ratio with capitation revenue net of premium tax was 92.3% for this period. UPRV's July 2018 MLRs were submitted on August 15, 2018. Based on an analysis of UPRV's July 2018 MLRs, for the period July 1, 2017, through December 31, 2017, the combined medical loss ratio was 91.2%. The reason for the noted decrease in the MLR percentage was due to adjustments of IBNR estimates. Over time, the IBNR estimates can be reduced with the submission and payment of actual claims.

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

D. Administrative Expenses and Management Agreement

For the year ended December 31, 2017, UPRV reported total Administrative Expenses of $539,419,295 which included direct expenses incurred by UPRV and administrative and support services fees paid pursuant to the management agreement between UPRV and USCRV. Administrative Expenses represented 13.2% of total premium revenue.

The administrative services agreement requires USCRV to perform certain administrative and support services necessary for the operation of UPRV for a fee based on (a) expenses for services or use of assets provided solely to the Company, and (b) the Company's allocated portion of expenses where the services or use of assets are shared among the Company and other Health Plans. These services include, but are not limited to, finance, management information systems, claim administration, telephonic member and provider services support, legal, regulatory, and provider credentialing. The fees paid to USCRV 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.

Additionally, UPRV has entered into an administrative services agreement with United Behavioral Health (UBH) to provide mental health and substance abuse services paid

on a per member per month rate. UBH is a related party to UPRV.

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

E. Schedule of Examination Adjustments to Capital and Surplus

No adjustments are recommended to Capital and Surplus for the period ending December 31, 2017, as a result of the examination of UPRV'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 UPRV, March Vision, the vision subcontractor and Tennessee Carriers, Inc., the NEMT subcontractor.

UPRV All TennCare Operations	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2017	98%	100.0%	**Yes**
February 2017	100%	100.0%	**Yes**
March 2017	100%	100.0%	**Yes**
April 2017	100%	100.0%	**Yes**
May 2017	99%	100.0%	**Yes**
June 2017	100%	99.9%	**Yes**
July 2017	100%	100.0%	**Yes**
August 2017	100%	100.0%	**Yes**
September 2017	100%	100.0%	**Yes**
October 2017	100%	100.0%	**Yes**
November 2017	99%	100.0%	**Yes**
December 2017	98%	99.9%	**Yes**

When combining the results for all claims processed, UPRV was in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for all months in 2017.

Prompt Pay Results for Vision

Prompt pay testing determined that claims processed by the vision subcontractor, March Vision, Inc., were in compliance with Section A.2.22.4 of the CRA for all months in calendar year 2017.

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 UPRV 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 UPRV and Tennessee Carriers, Inc., processed NEMT claims in compliance with the requirements of Section A.2.22.4, of the CRA for all months in calendar year 2017.

Prompt Pay Results for CHOICES Claims

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

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

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

Prompt pay testing determined that CHOICES claims were processed in compliance with Section A.2.22.4.4 of the CRA for all months in calendar year 2017.

Prompt Pay Results for ECF CHOICES HCBS Claims

Pursuant to Section A.2.22.4.4 of the CRA, UPRV is required to separately 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 for 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 ECF CHOICES HCBS shall be processed and paid within twenty-one (21) calendar days of receipt.

Prompt pay testing determined that UPRV ECF CHOICES HCBS claims were processed in compliance with Section A.2.22.4.4 of the CRA for all months in calendar year 2017.

Prompt Pay Results for Community Mental Health Center (CMHC) Claims

UPRV arranges for the provision of supported housing services through contracts with CMHCs which have in turn subcontracted with individual supported housing providers. The CMHCs had developed a payment mechanism with the supported housing providers that was not reflected in the prompt pay data files submitted by UPRV. Due to the low volume of claims processed by the CMHCs, TDCI discontinued requiring UPRV to submit separate monthly prompt pay data files for supported housing providers for the foreseeable future. Additionally, in coordination with the Division of TennCare, TDCI has requested that UPRV ensure the CMHCs complete a monthly claims inventory report for the purpose of monitoring the effectiveness of supported housing claims processing. In the event TDCI determines the submission of the monthly inventory reports is inadequate for ensuring timely payment of supported housing claims, TDCI will consider reinstituting the data file submission requirement. Also, UPRV will ensure that supported housing providers are aware of provider complaint processes available through TDCI.

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 UPRV's claims processing system. The following items were reviewed to determine the risk that UPRV 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.

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

C. Claims Payment Accuracy

1. Claims Payment Accuracy Reported by UPRV

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, UPRV submits claims payment accuracy percentage reports by Grand Region to TennCare based upon audits conducted by UPRV. 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 UPRV are defined in the CRA between UPRV 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.

UPRV failed to achieve the contractual requirement of 97% claims payment accuracy during calendar year 2017 for the following regions, months, and claim types:

East Tennessee Region

Month of Filing	Claim Type	Percentage Reported
February 2017	Nursing Facility	95%
September 2017	Medical	95%

Middle Tennessee Region

Month of Filing	Claim Type	Percentage Reported
June 2017	Nursing Facility	96%
August 2017	Nursing Facility	95%

West Tennessee Region

Month of Filing	Claim Type	Percentage Reported
June 2017	HCBS	95%
October 2017	Nursing Facility	95%

As each failure was reported, TDCI requested corrective actions plans. When UPRV identified system errors in the corrective plans TDCI followed up until the system issue was resolved. During 2017 the Division of TennCare assessed UPRV $40,000 in liquated damages related to claims payment accuracy failures for medical, nursing facility and CHOICES claim types.

Management Comments

Management concurs. We agree that UPRV received the findings listed above in 2017. We engaged in corrective action for each of the findings and notified TDCI of that action at the time. TDCI agreed with our remediation and has closed all Corrective Action Plan requests.

2. Claims Payment Accuracy Reported for NEMT

ATTACHMENT XI Section A.15.5 of the CRA requires UPRV to pay 97% of Non-Emergency Medical Transportation (NEMT) claims accurately upon initial submission. Additionally, ATTACHMENT XI Section A.15.6 of the CRA requires an audit of NEMT claims that complies with the requirements in the CRA regarding a claims payment accuracy audit. The NEMT subcontractor, Tennessee Carriers Inc., performed the audit and reported compliance with monthly claims payment accuracy requirements for all months in calendar year 2017.

3. Procedures to Review the Claims Payment Accuracy Reports

The review of the claims payment accuracy reports included interviews with responsible staff of UPRV, March Vision, 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 UPRV, the NEMT subcontractor and the vision subcontractor agreed to requirements of Section A.2.22.6 and ATTACHMENT XI Sections A.15.5 and A.15.6 of the CRA. These interviews were followed by a review of the supporting documentation used to prepare the claims payment accuracy reports.

From UPRV's December 2017 claims payment accuracy reports, TDCI selected for verification 33 claims (29 medical claims and 4 March Vision claims) reported as errors and 25 claims reported as accurately processed. For claims that were considered errors, testing focused on the type of error (manual or system) and whether the claim was reprocessed. For claims that were reported as accurately processed by UPRV, 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

   a. The following deficiencies were noted in TDCI's reverification of the thirty-three claims (twenty-nine medical claims and four March Vision claims) reported as errors:

      - Eight of the 29 medical claims that UPRV tested and determined were inaccurately processed in December 2017 were not corrected by UPRV as of fieldwork during August 2018. UPRV should develop controls to ensure that claims identified as errors during the claims payment accuracy testing are corrected in a timely manner.

      - Two of the four vision claims that March Vision tested and determined were inaccurately processed in December 2017 were not corrected by March Vison as of field work in August 2018. March Vison should develop controls to ensure that claims identified as errors during the claims payment accuracy testing are corrected in a timely manner.

      - CRA Section A.2.22.6.4.5 states that the claim tests shall include verification that the allowed payment amount agrees with the contracted rate and the terms of the provider agreement. TDCI noted that March Vison does not trace the payment rate for the claims back to the executed provider agreement when performing claims payment accuracy testing.

        Management Comments

        Management concurs. In Q4 2018, UPRV and March Vision implemented process controls to ensure all claims identified, as a result of a claim payment accuracy audit, are resolved timely. In addition, controls were implemented to review the payment rate against the executed provider agreement to verify accuracy.

   b. No deficiencies were noted in TDCI's reverification of twenty-five claims reported as accurately processed.

D. Focused Claims Testing

CRA Section A.2.22.7 requires UPRV 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 UPRV.

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 UPRV during calendar year 2017, TDCI judgmentally selected 25 claims per Grand Region from the data files submitted by UPRV for prompt pay testing purposes. The focused areas for testing during calendar year 2017 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 UPRV with the claims selected for testing and specified the attributes for UPRV to self-test to determine if the claims were accurately processed. For the 900 claims tested for the calendar year 2017, UPRV reported at least one attribute error on 184 claims. It should be noted a claim may fail more than one attribute. For the 184 claims, 373 attribute errors were reported by UPRV. The following table summarizes the focused claims testing errors reported by UPRV for the calendar year 2017:

Attribute Tested	Errors Reported by UPRV
Data Entry is Verified with Hardcopy Claim	2
Correct provider is Associated to the Claim	18
Authorization Requirements Properly Considered	91
Member Eligibility Correctly Considered	12
Payment Agrees to Provider Contracted Rate	8
TennCare Rate Reduction and Restorations Applied to Payment	0
Duplicate Payment Has Not Occurred	4
Denial Reason Communicated to Provider Appropriate	175
Modifier Codes Correctly Considered	43
Other Insurance Properly Considered	6
Patient Liability Correctly Applied	0
Coding-Bundling/Unbundling Properly Considered	0
Application of Benefit Limits Considered	14
Considered Benefit Limit HCBS Provided as Cost Effective Alternative	0
Application of Expenditure Cap for Member in Group 3 Considered	0
Total	373

For the 184 claims that contained attribute errors, UPRV identified 11 that were the result of system errors and 362 that were the result of manual errors. For the system errors, UPRV provided explanations which identified the error that occurred, identified the number of claims effected, and reported when all effected 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. We agree that UPRV received the findings listed above in 2017. We engaged in corrective action for each of the findings and notified TDCI of that action at the time. TDCI agreed with our remediation and has closed all Corrective Action Plan requests.

2. Deficiencies Noted by TDCI During Focused Claims

   TDCI noted additional claims processing deficiencies in addition to the errors identified by UPRV during monthly focused testing. For each deficiency, TDCI requested UPRV provide additional explanation including the resolution of system configuration issues and the reprocessing of the error claim and all other affected claims. The following represent the additional items noted by TDCI during monthly focused testing for calendar year 2017:

a. Authorization Issues

- For three claims in February 2017, UPRV indicated there were system errors due to improper entry of the authorizations. The authorizations for Attendant Care services were approved to exceed the Plan Limit. However, the UD modifier was erroneously omitted from the claim's authorization and the claim denied incorrectly for plan limit exceeded. This error impacted an additional 780 claims. UPRV indicated all claims were reprocessed in March 2017.

- For one claim in May 2017, UPRV indicated the claim was denied in error due to changes in the member's eligibility which caused the original authorization to be deleted. In the process of correcting this system error, UPRV erroneously entered new authorizations which resulted in a total of 19 claims paying incorrectly. UPRV indicated the impacted claims have been reprocessed.

- For nine claims in August 2017, UPRV indicated the claims were incorrectly denied for no authorization. UPRV stated that authorizations for PERS services were not carried over from the previous year as cited in the plan of care for 2017 dates of service. In the process of correcting this error, UPRV noted five additional claims incorrectly denied for no authorization. UPRV indicated all impacted claims have been reprocessed.

Management Comments

Management concurs. UPRV updated its system to allow the term date of one plan to be entered as the effective date of the new plan and enhancements were made to correctly load the Personal Emergency Response System (PERS) benefits in Q4 2017. In addition, the authorization team established guidelines to support manual processing instructions for reference.

b. Retroactive Eligibility

Twelve claims in calendar year 2017 were inappropriately denied for exceeding timely filing limits. The members were retroactively eligible, and the claims should have been paid. While reprocessing the twelve error claims, UPRV identified an additional 32 claims that were denied incorrectly. In a corrective action plan, UPRV indicated corrective actions have been implemented to identify retroactively enrolled members, to identify their claims in the claim system, and to reprocess all denied claims received within 120 days of the notification of the enrollment date. UPRV stated all affected claims identified in the focused claim testing have been reprocessed.

Management Comments

Management concurs. UPRV developed a semi-automated solution that was implemented in February 2018 and CSP Facets logic was enhanced in August 2018 to fully automate the process.

c. Provider Network Setup Issue

For one claim in April 2017, UPRV noted a system error that inappropriately denied claims for no authorization where the provider is a contracted health department. As a result, all contracted health department claims were processed as out of network causing the claims to deny in error for no authorization. A total of 748 claims with total billed charges of $74,589.40 were impacted by this error for this health department. UPRV indicated that all claims for this provider have been corrected; however, all contracted health departments are impacted. Total claims and dollar amounts are unknown. Dates impacted are January 1, 2015 to August 2018. The Division of TennCare is aware of this matter and working with UPRV on corrections and claims adjustments.

Management Comments

Management concurs. Remediation is in place. A comprehensive audit was performed in February 2018 that identified several locations with incorrect demographics which caused the incorrect denials in CSP Facets. All demographics have been updated and all claims have been reprocessed as of November 2018.

d. Encounter Data Issues

Four paid claims in three separate monthly focused testing were not successfully submitted to the Division of TennCare as encounter data because the claims failed the Division of TennCare's claims compliancy edit checks. Per Section A.2.23.4 of the CRA, UPRV's claims management system shall conform to HIPAA standard transaction code sets in order to submit encounter data to the Division of TennCare. All four claims were subsequently corrected, and the encounter data was successfully submitted to the Division of TennCare. While researching this encounter data issue, UPRV discovered that 221 Tennessee Carriers claims with dates of service prior to January 1, 2017, had not been submitted as encounter data to the Division of TennCare. UPRV indicated as of September 2017, all 221 claims have been submitted for encounter data. UPRV provided information on a series of system enhancements that has been implemented to correct system errors related to compliancy edits.

Management Comments

Management concurs. UPRV is in process of remediating this issue. The clarity provided by CRA Amendment 9 effective January 1, 2019 will drive the remediation activities.

e. Unable to Differentiate between Attending Providers

For one claim in November 2017, UPRV incorrectly denied the claim as duplicate because the system was not configured to differentiate between attending providers. The claim's dates, service codes, and modifiers matched another claim with the same dates, service codes, and modifiers. UPRV indicated that the error was a system error that impacted a total of 19 claims in the dollar amount of $980.49. UPRV further indicated that an edit has been put in place to force the claims processor to follow the standard operating procedure that would prevent this type error in the future. Additionally, UPRV indicated the impacted claims have been reprocessed.

Management Comments

Management Concurs. In December 2017, UPRV enhanced an edit that identifies potential duplicates for same day services. In addition, UPRV has weekly touchpoints to monitor activity.

3. Verification by TDCI of Focused Claims Testing Results

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

- TDCI judgmentally selected 47 claims for testing in which no errors were reported by UPRV. Of the 47 claims selected, five were processed by March Vision and five were processed by Tennessee Carriers.

- TDCI judgmentally selected 25 claims for testing in which UPRV reported errors.

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

a. During the review of the 47 no error claims selected for testing, TDCI noted the following:

    - During the review of the procedures utilized by UPRV when testing the attribute "Payment agrees to provider contracted rate", it was noted that UPRV does not verify the claim pricing accuracy with payment terms in the executed provider contract. UPRV cannot accurately test this attribute without comparing the payment to the contracted fee schedule.

- For one claim in August 2017, TDCI noted that UPRV incorrectly paid a nursing facility claim that should have denied for spanning multiple months. UPRV failed to assess that the claim had been incorrectly processed in their response to focused testing. Additionally, TDCI noted two subsequent submissions with inclusive dates of service were also incorrectly paid because UPRV's duplicate processing logic failed to recognize the previous payment.

Management Comments

Management concurs. UPRV confirms the systems pricing is accurate by comparing the payment terms with the executed provider contract. UPRV corrected the configuration to deny nursing facility claims that exceed one calendar month in September 2018 which remediates the duplicate payment of overlapping months.

b. During the review of the 25 claims in which UPRV reported processing errors, TDCI noted one of the claims reported as an error during the 2017 focused claims test work was not corrected by UPRV as of the August 2018 fieldwork. UPRV should develop controls to ensure that claims identified as errors during the focused claims testing are corrected in a timely manner.

Management Comments

Management concurs. In Q4 2018, UPRV implemented process enhancements to ensure all identified claims as a result of a claim payment accuracy audit are resolved timely.

E. Copayment Testing

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

TDCI requested from UPRV a listing of the 100 enrollees with the highest accumulated copayments for the period January 1, through December 31, 2017. From the listing, five enrollees were judgmentally selected, and all of the claims processed for those enrollees in calendar year 2017 were analyzed to determine if UPRV had correctly applied copayment requirements of the CRA based upon the enrollees' eligibility status. During the review TDCI noted that for two enrollees, UPRV incorrectly applied the copayment. The copayment amount for Community Mental Health services should have been $15, but UPRV applied a $5 copayment.

Management Comments

Management concurs. CSP Facets is in the process of being updated to reflect the appropriate copays and completion date is targeted for end of December 2018. A claim processing work-around was implemented on 12/4/2018 to ensure correct copay application until CSP Facets configuration update is complete

F. Remittance Advice Testing

The purpose of remittance advice testing was to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system. No discrepancies were noted.

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

The purpose of analyzing cancelled checks and/or EFT was to: (1) verify the actual payment of claims by UPRV; 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 UPRV to provide thirty cancelled checks or EFT documentation related to claims previously tested by TDCI. UPRV 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 July 31, 2018, were reviewed for claims which were unprocessed and exceeded 60 days old from receipt date. The pended and unpaid data file of claims unprocessed by UPRV, as well as subcontractors, indicate a total of 10,022 claims exceeding 60 days in process. UPRV, including subcontractors, processed 613,032 initial submission claims for the month of July 2018, thus, it does not appear that a material liability exists for claims over 60 days old.

I. Mailroom and Claims Inventory Controls

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

The mailroom function is subcontracted to Firstsource Solutions USA, Inc. (Firstsource). Firstsource's office in Kingston, New York, receives, sorts, scans, enters data, and reconciles all medical claims and correspondence received from UPRV

providers and members. TDCI did not perform a site visit of the mailroom operations during this examination. UPRV provided responses to internal control questionnaires, flowcharts, and claims inventory reconciliation reports regarding mailroom operation. No additional test work of mailroom procedures was performed. No reportable deficiencies were noted by TDCI during the review of the mailroom and claim inventory controls.

VII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints Received by UPRV

Provider complaints were tested to determine if UPRV 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 2017 provider appeal logs to verify the timeliness of provider reconsideration requests. TDCI judgmentally selected sixteen (16) provider complaints/appeals for testing and found that one provider complaint, which took 199 days to resolve, was not processed in accordance with timeliness requirements of Tenn. Code Ann. § 56-32-126(b)(2)(A).

> First, UPRV failed to inform the provider that the plan needed longer than 30 calendar days to completely respond to the complaint. Further, UPRV could not provide a written agreement with the provider to allow for more than 60 days to resolve the complaint as required.

Management Comments

Management concurs. In September 2018, UPRV enhanced the process of monitoring responses to providers. In the event a complaint, appeal or grievance response will not be available within the 30 day requirement, UPRV will provide notification to the State and provider at least 24 hours in advance.

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. During calendar year 2017, the MCO was required to respond in writing within 30 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, 2017, TDCI received and processed 356 provider complaints against UPRV. The responses by UPRV to providers were categorized by TDCI in the following manner:

Previous denial or underpayment reversed in favor of the provider	166
Previous denial or payment upheld	139
Previous denial or underpayment partially reversed in favor of the provider	26
Paid by UPRV upon Receipt of Complaint	2
Other inquiries	11
Ineligible or duplicate	12

TDCI judgmentally selected 23 of these provider complaints for review. The issues raised by the providers were analyzed and questions were posed to UPRV for response. Emphasis was placed on discovering deficiencies in the UPRV's claims processing system or provider complaint procedures. For the 23 provider complaints selected for testing, no reportable deficiencies were noted.

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, 2017, 64 independent reviews were initiated by providers against UPRV. The following is a summary of the reviewer decisions:

Reviewer decision in favor of UPRV	28
Reviewer decision in favor of the provider	11
Settled for the provider	15
Previous denial or underpayment partially reversed in favor of the provider	10

TDCI judgmentally selected five independent reviews for testing. The issues raised by the providers were analyzed and questions were posed to UPRV for response. Emphasis was placed on discovering deficiencies in the UPRV's claims processing system or provider complaint and appeal procedures. For the 5 independent reviews selected for testing, no reportable deficiencies were noted.

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. UPRV routinely submits updates to the provider manual to TDCI for prior approval. An update to the provider manual was accepted by TDCI on August 2, 2018.

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.)

TDCI requested the executed provider agreements for the 47 claims tested above in Section VI.D.3. TDCI noted that 39 of the 47 provider agreements tested failed to comply with Section A.2.12.9.48 of the CRA. The provider agreement regulatory appendix was updated through modifications to the provider manual; however, there was no evidence that the providers were given notice of the regulatory amendment through the provider manual update or that the providers were given 30 calendar days to give notice of rejection.

Management Comments

Management concurs. In November 2018, UPRV enhanced the provider portal to include the regulatory requirements appendix as a stand-alone document. UPRV will notify providers of the updated document via periodic communication such as email blast, provider newsletters, and bulletins. UPRV is enhancing processes to comply with A.2.12.9.48 of the CRA.

F. Provider Payments

Capitation payments to providers were tested during 2017 to determine if UPRV complied with the payment provisions set forth in its capitated provider agreements. TDCI selected a sample of capitated payments from the December 2017 East Tennessee MLR report. 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.

- One of the five executed subcontracts selected for testing had never been submitted to TDCI and the Division of TennCare for prior approval. The subcontractor, Health Management Systems, Inc., provides reclamation billing and recovery services, prospective COB identification, and waste/error facility audits.

The subcontractor utilizes member protected health information. The subcontract should have been prior approved by TDCI and the Division of TennCare. Additionally, the subcontractor is a related party to UPRV. Tenn. Code Ann. § 56-11-106(a)(2) says in part that transactions involving an HMO and any person in its holding company system may not be entered into unless the HMO has notified the commissioner in writing of its intention to enter into the transaction at least thirty days prior. This agreement should have been filed as a Form D, Prior Notice of Transaction, due to the affiliated relationship.

- UPRV has an approved subcontract with March Vision Care Group, Inc. for vision services management, payment of vision claims, and management of the vision network. However, March Vision Care Group, Inc., subcontracts management services to March Vision Care, Inc., an entity which is wholly owned by UnitedHealth Group, Inc. The subcontract between March Vision Care Group, Inc. and March Vision Care, Inc. has not been submitted to TDCI and the Division of TennCare for approval.

Management Comments

Management concurs. UPRV has submitted the management agreement between March Vision Care Group, Inc. and March Vision Care, Inc. to TDCI for approval and it has been approved by TDCI on 10/19/18. UPRV is in process of preparing to submit the subcontract agreement, with Health Management Systems, Inc. to TDCI, along with the Form D.

H. Subcontractor Monitoring

The CRA between UPRV and the Division of TennCare allows UPRV to delegate activities to a subcontractor. UPRV is required to reduce subcontractor agreements to writing and specify the activities and report responsibilities delegated to the subcontractor. UPRV should monitor the subcontractor's performance on an ongoing basis. Also, UPRV should identify any deficiencies or areas for improvement and determine the appropriate corrective action as necessary. Section A.2.26.1 of the CRA states, "If the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6." Additionally, Section A.2.26.8 requires UPRV 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 UPRV to provide documentation of its efforts to monitor subcontractor's compliance with CRA requirements. No deficiencies were noted during the review of UPRV's subcontractor review tools and monitoring efforts.

I. Non-discrimination

Section A.2.28.2 of the CRA requires UPRV to demonstrate compliance with Federal and State regulations of Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age of Discrimination Act of 1975, and the Omnibus Budget Reconciliation Act of 1981. Based on discussions with various UPRV staff and a review of policies and related supporting documentation, UPRV 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 UPRV's parent company, UnitedHealth Group, performs internal audits specific to the TennCare plan. The results of the specific reviews by the Internal Audit Department were considered by TDCI during the current examination. The report included findings and responses through Agreed-Upon Action Plans by UPRV's management.

As previously noted, Section A.2.21.10 of the CRA requires the claims payment accuracy reports be prepared by the plan's Internal Audit Department. The reports are not prepared by UPRV's Internal Audit Department but rather by a unit within UPRV's Claims Operations Department. The Division of TennCare granted a deviation to this CRA requirement to permit staff other than UPRV's Internal Audit Department to prepare the claims payment accuracy reports.

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 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner…." UPRV is domiciled in the State of Illinois. TDCI interprets the Act as applying to foreign health maintenance organizations in a manner that treats such foreign entities as a domestic insurer for the purposes of being regulated under the Act. Through a Memorandum of Understanding executed January 14, 2013, UPRV agreed to TDCI's interpretation and consented to be regulated as a domestic insurer under the Act. The review of the annual filing for

Illinois is required to also be submitted to TDCI. No discrepancies were noted in the annual holding company registration filing received in 2018 for the calendar year 2017.

L. Health Insurance Portability and Accountability Act (HIPAA)

Section A.2.27 of the CRA requires UPRV to comply with requirements of the Health Insurance Portability and Accountability Act of 1996 and Health Information Technology for Economic and Clinical (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.

UPRV's and its subcontractor's information systems policies and procedures were reviewed in relation to the HIPAA requirements of the CRA. No deficiencies were noted during the review of policies and procedures related to HIPAA 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 or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to UPRV in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

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

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

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

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

- The most recently approved provider agreement templates contain the conflict of interest language of the CRA.

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

TDCI noted no instances of non-compliance with conflict of interest requirements for UPRV 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 or specialty driven 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 gain sharing and risk sharing payments 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 risk sharing payment 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 of the accuracy of the reports prepared by the MCOs. From listings of all enrollee episodes in a quarter, TDCI randomly selected for testing 25 enrollee episodes 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, TDCI selected for testing enrollee episodes excluded from the PAPs average cost calculations.

TDCI randomly selected for testing 25 enrollee episodes included from final and interim reports issued by UPRV in August 2017 for calendar year 2016. Also, TDCI selected for testing 30 enrollee episodes excluded from the PAP average cost calculations. The following table reports the results of episode of care testing by episode of care from final and interim reports issued by UPRV in August 2017.

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?	1

In the 30 episodes selected for testing that were excluded from the Principal Accountable Providers' average cost calculations, one episode was incorrectly excluded as an episode where the episode trigger occurred in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC). UPRV was requested to identify the claim number and the Service Place or Type of Bill Code that identified the episode trigger as occurring in a FQHC or RHC. Optum, the subsidiary of UnitedHealth Group that processed the episode of care data for UPRV responded through UPRV that a correction was made post August processing to correctly include the episode. They determined that there was not a financial impact for the provider on gain or risk sharing.

Management Comments

Management concurs. In August 2017 the configuration was adjusted to correct the cause of this error.

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

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, 2015:

A. Supplemental Compensation Exhibit

The allocation methodology utilized by UPRV materially understates the compensation reported for the employees tested on the 2015 Supplemental Compensation Exhibit. A fairer representation and reporting of compensation on the schedule would be an allocation based upon time dedicated to UPRV responsibilities.

B. Claims Processing Deficiencies

1. UPRV failed to achieve compliance with Section A.2.22.4 of the Contract requirements for timely processing of CHOICES claims for the months January, February, April and May 2015.

2. For four months in East Tennessee Region and six months in Middle Tennessee Region, UPRV failed to achieve claims payment accuracy requirements of 97% per Section A.2.22.6 of the CRA for medical claims.

3. For four months in East Tennessee Region, one month in Middle Tennessee Region and one month in West Tennessee Region, UPRV failed to achieve claims payment accuracy requirements of 97% per Section A.2.22.6 of the CRA for nursing facilities claims.

4. For four months in East Tennessee Region, three months in Middle Tennessee Region and two months in West Tennessee Region, UPRV failed to achieve claims payment accuracy requirements of 97% per ATTACHMENT XI Section A.15.5 of the CRA for NEMT claims.

5. The review of the claims payment accuracy reports testing results for calendar year 2015 indicated the following deficiencies:

   a) One of the twenty claims that UPRV determined was inaccurately processed in December 2015 was not corrected by UPRV as of fieldwork during August 2016.

   b) One of the twenty claims TDCI tested was determined by UPRV to have been accurately paid according to the provider agreement. However, testing by TDCI noted that the amount paid by UPRV could not be verified against the payment terms of the provider agreement.

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

6. The CRA requires UPRV to self-test the accuracy of claims processing based on claims selected by TDCI on a monthly basis. For the 900 claims tested for the calendar year 2015, UPRV reported at least one attribute error on 214 claims during this focused claim testing.

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

   a) Multiple claims were denied with the only denial reason communicated to the provider is "claim lacks needed information" or "payment adjustment submission/billing error". These are vague denial explanations and do not provide enough information for the provider to correct the claim.

   b) Multiple claims were inappropriately denied for exceeding timely filing limits. The members were retroactively eligible, and the claims should have been paid. UPRV indicated a corrective action plan has been implemented to identify retroactively enrolled members and to identify their claims in the claim system and reprocess all denied claims received within 120 days of the notification of the enrollment date.

   c) Multiple paid claims were not successfully submitted to TennCare as encounter data because the claims failed the Division of TennCare's claims compliancy edit checks. Encounter data for all paid claims must be submitted to TennCare.

8. TDCI reviewed 36 claims reported by UPRV as being processed correctly during focused claims testing for the calendar year 2015. TDCI noted the following discrepancies:

   a) UPRV does not verify the claim pricing accuracy with payment terms in the executed provider contract.

   b) One claim that UPRV determined was accurately processed was in fact not a claim but rather a document submitted by a provider which requested a prior authorization. The submitted document did not report a date of service since no service was performed. UPRV erroneously entered the received date of the document as the procedure date of service. The document should never have been entered as a claim and submitted to TDCI for prompt pay calculations.

   c) One claim that UPRV determined was accurately processed was denied with the denial reason code "need the primary carrier EOB." The date of service for the claim was during calendar year 2015. The denial reason code was inappropriate since UPRV was aware that the member's commercial policy terminated on February 11, 2005. The claim should have been reported as inaccurately processed by UPRV during focused testing.

9. TDCI reviewed 25 claims reported by UPRV as being processed incorrectly during focused claims testing for the calendar year 2015. TDCI noted one of the 25 claims that UPRV reported as inaccurately processed was not corrected by UPRV as of fieldwork during August 2016.

10. For three of five enrollees selected for copayment testing, errors were discovered in the application of copayments.

    a) For two enrollees, UPRV incorrectly applied a copayment of $15 for several physician specialist visits instead of applying a $20 copayment per CRA requirements.

    b) For one enrollee, UPRV incorrectly applied a copayment of $20 for several primary care provider visits instead of applying a copayment of $15 per CRA requirements.

    c) For two enrollees, UPRV did not apply a $50 copayment per CRA requirements for emergency room visits.

Findings 7.b, 7.c, and 8.a have been repeated in the current examination.