STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE OVERSIGHT DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

and

FINANCIAL AND COMPLIANCE EXAMINATION

OF

THE TENNCARE OPERATIONS

OF

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

d/b/a UnitedHealthCare Community Plan

NASHVILLE, TENNESSEE

FOR THE PERIOD JANUARY 1, 2021
THROUGH DECEMBER 31, 2021

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DATE:	January 31, 2023

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 October 7, 2022. The report of this examination is herein respectfully submitted.

I. FOREWORD

On April 18, 2022, 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. Remote fieldwork began on August 22, 2022 and ended on October 7, 2022. All document requests and the signed management representation letter were provided by October 7, 2022.

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, 2021.

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

Effective December 31, 2019, UPRV is a wholly owned subsidiary of UnitedHealthcare, Inc. ("UHC"). Prior to December 31, 2019, the Company was a wholly owned subsidiary of UnitedHealthcare Services Company of the River Valley, Inc. ("UHS-RV") which in turn was a wholly owned subsidiary of UHC. UHS-RV merged with and into UHC on December 31, 2019, resulting in UHC being the Company's immediate parent. UHC is a wholly owned subsidiary of United

HealthCare Services, Inc. ("UHS"), a management corporation that provides services to the Company under the terms of a management agreement. UHS is a wholly owned subsidiary of UnitedHealth Group Incorporated. UnitedHealth Group, Inc., 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 on December 31, 2021, were as follows:

Officers for UPRV

Ute Wegfarth Strand, President
Peter Marshall Gill, Treasurer
Heather Anastasia Lang, Secretary
James Wesley Kelly, Chief Financial Officer
Nyle Brent Cottington, Vice President
Jessica Leigh Zuba, Assistant Secretary
Robert Andersen Broomfield, President, Commercial

Directors or Trustees for UPRV

Robert Andersen Broomfield
Cathie Sue Whiteside
William Kenneth Appelgate, PhD.
Scott Edward Williams
Ute Wegfarth Strand
James Edward Hecker
Brendan Paul Hostetler
James Wesley Kelly

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.

As of December 31, 2021, UPRV had approximately 489,000 TennCare members state-wide. The TennCare benefits required to be provided by UPRV are:

- Medical
- Behavioral health
- Vision
- Long-term services and Home and Community Based Services (“CHOICES” program)
- Employment and Community First (“ECF CHOICES” program)
- Non-emergency transportation services

Effective March 1, 2010, the CRA between UPRV 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, 2021, UPRV had approximately 26,332 enrollees assigned to the CHOICES program.

Effective September 1, 2017, UPRV began offering services through the Employment and Community First (ECF) CHOICES program. ECF CHOICES is a 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, 2021, UPRV had 3,863 enrollees in the ECF CHOICES program.

For the period January 1, 2021, through December 31, 2021, UPRV received 59% of its nationwide revenue and 61% of its Tennessee revenue from payments for providing TennCare covered services to members.

Effective January 1, 2021, UPRV administers the CoverKids program through an at-risk arrangement with TennCare. The Children’s Health Insurance Program (CHIP) is a federally sponsored program that provides health insurance to uninsured children. In Tennessee, this program is called CoverKids and includes children under age 19 and eligible mothers of unborn children who do not qualify for TennCare but meet certain income limits. For the year ending December 31, 2021, UPRV had approximately 14,900 CoverKids enrollees in Tennessee.

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, 2021, UPRV had approximately 64,300 Medicare enrollees 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. (March Vision), for vision benefits and the processing and payment of related claims submitted by vision providers.

- Tennessee Carriers, Inc. (Tennessee Carriers), 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. Prompt pay testing by TDCI determined that ECF CHOICES claims were not processed in compliance with Section A.2.22.4 of the CRA for the months of February, July, and December 2021.

   (See Section VI.A. of this report)

2. For one month in the West Tennessee Region, UPRV failed to achieve claims payment accuracy requirements of 97% per Section A.2.22.6 of the CRA for ECF CHOICES claims.

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

3. The CRA requires UPRV to self-test the accuracy of claims processing based on claims selected by TDCI on a monthly basis. For the 1,175 claims tested for calendar year 2021, UPRV reported at least one attribute error on 96 claims during focused claims testing.

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

4. During the review of focused claims testing results, TDCI noted twenty-five (25) additional claims processing deficiencies that resulted in the reprocessing of 12,285 claims with billed charges of $8,746,705. Details of the additional deficiencies are described in this report.

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

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

   (See Section VI.E)

C. Compliance Deficiencies

1. For two of the sixteen provider complaints reviewed from the test month of December 2021, manual errors caused claims to incorrectly deny on initial submission.

   (See Section VII.A. of this report)

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

   (See Section VII.B. 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, 2021, UPRV reported $1,199,215,830 in admitted assets, $776,599,783 in liabilities and $422,616,047 in capital and surplus on the 2021 Annual Statement submitted February 28, 2022. UPRV reported total net income of $200,586,206 on the statement of revenue and expenses. The 2021 Annual Statement and other financial reports submitted by UPRV can be found 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 Tenn. Code Ann. § 56-46-201 et seq. UPRV has submitted a report of risk-based capital (RBC) levels as of December 31, 2021. The report calculates 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, 2021, UPRV maintains an excess of capital over the amount produced by the Company Action Level Events calculations required by Tenn. Code Ann. § 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, 2021, reported capital and surplus to the Company Action Level requirements:

Reported Capital and Surplus	$ 422,616,047
Reported Authorized Control Level Risk-Based Capital	$ 49,962,921
Computed and Required Company Action Level Risk-Based Capital (200% of Authorized Control Level)	$99,925,842

   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, 2021, 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, 2021, 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, 2021.

(1) For the period ending December 31, 2021, UPRV reported total company premium revenues of $3,409,890,606, on the 2021 NAIC Annual Statement (Schedule T total).

(2) For the period ending December 31, 2021, UPRV received total medical payments from the Division of TennCare of $2,471,665,757, and all other premiums and consideration of $1,400,345,462 (Schedule T total premiums less Tennessee Medicaid premiums), for a total of $3,872,011,219.

Utilizing $3,872,011,219 as the premium revenue base, UPRV's minimum net worth requirement as of December 31, 2021, is $61,830,168 ($150,000,000 x 4% + ($3,872,011,219 - 150,000,000) x 1.5%). UPRV's reported net worth at December 31, 2021, was $360,785,879 in excess of the required minimum net worth.

2. <u>Restricted Deposit</u>

Tenn. Code Ann. § 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 Tenn. Code Ann. § 56-32-112(b). Utilizing total medical payments from the Division of TennCare of $2,471,665,757, and all other Tennessee premiums and consideration of $1,284,370,898, the premium revenue base is $3,756,036,746. UPRV's calculated restricted deposit requirement as of December 31, 2021, is $20,000,000. As of December 31, 2021, UPRV had on file with TDCI, a depository agreement and properly pledged safekeeping receipts totaling $25,000,000 to satisfy restricted deposit requirements.

3. Claims Payable

UPRV reported $307,223,007 claims unpaid as of December 31, 2021. Of the total claims unpaid reported, $188,518,914 represented the claims unpaid for TennCare operations and $3,006,197 claims unpaid for CoverKids. The reported amount was certified by a statement of actuarial opinion.

Analysis by TDCI of the triangle lag payment reports through June 30, 2022, for dates of services before January 1, 2022, 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, 2021, UPRV's TennCare Operating Statement reported Total Revenues of $2,051,022,061, Medical Expenses of $1,561,416,423, Administrative Expenses of $323,773,164, Income Tax Expense of $34,824,820, and Net Income of $131,007,655.

No reportable deficiencies were noted in the preparation of the TennCare Operating Statements for the period ending December 31, 2021. The TennCare Operating Statements are separate schedules in the UPRV 2021 NAIC Annual Statement which can be found at https://www.tn.gov/content/dam/tn/commerce/documents/tcoversight/reports/2022/UPRV_Q4_NAIC_030422.pdf .

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, 2021, through December 31, 2021, were submitted January 19, 2022. Based on TDCI's analysis, the combined MLR with capitation revenue net of premium tax was 88.7% for this period. UPRV's August 2022 MLRs were submitted on September 20, 2022. Based on an analysis of UPRV's August 2022 MLRs, for the period July 1, 2021, through December 31, 2021, the combined MLR was 87.9%. The reason for the noted decrease in the MLR percentage was due to adjustments of IBNR estimates as well as an underutilization of routine medical procedures during the covid-19 pandemic. Over time, the IBNR estimates can be reduced with the submission and payment of actual claims.

UPRV submits MLR reports for CoverKids 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 CoverKids. CoverKids MLR for the period July 1, 2021, through December 31, 2021, was submitted January 19, 2022. Based on TDCI's analysis, the MLR with capitation revenue net of premium tax was 80.6% for this period. UPRV's CoverKids August 2022 MLRs were submitted on September 20, 2022. Based on an analysis of UPRV's CoverKids August 2022 MLRs, for the period July 1, 2021, through December 31, 2021, the MLR was 87.1%. The CoverKids MLR approximates the combined MLR percentage for all of UPRV.

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

D. Administrative Expenses and Management Agreement

For the year ended December 31, 2021, UPRV reported General Administrative Expenses of $292,807,214 which included direct expenses incurred by UPRV and administrative and support services fees paid pursuant to the management agreement between UPRV and UHS. Administrative Expenses represented 8.9% of total premium revenue.

Effective 2012, the company entered into an administrative services agreement with its affiliated companies which the Department approved on October 15, 2012. 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 UHS 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, 2021, management fees/allocated expenses of $160,410,070 were charged to UPRV by UHS for TennCare operations. The management fee represented approximately 8% of total premium revenue.

Additionally, UPRV has entered into an administrative services agreement with United Behavioral Health (UBH) for 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, 2021, 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, 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 2021	100%	100.0%	**Yes**
February 2021	99%	99.9%	**Yes**
March 2021	100%	100.0%	**Yes**
April 2021	100%	100.0%	**Yes**
May 2021	100%	99.9%	**Yes**
June 2021	100%	100.0%	**Yes**
July 2021	100%	100.0%	**Yes**
August 2021	100%	100.0%	**Yes**
September 2021	100%	100.0%	**Yes**
October 2021	100%	99.9%	**Yes**
November 2021	100%	100.0%	**Yes**
December 2021	100%	100.0%	**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 2021.

Prompt Pay Results for Vision

Prompt pay testing determined that claims processed by the vision subcontractor, March Vision, were in compliance with Section A.2.22.4 of the CRA for all months in calendar year 2021.

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:

- 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, processed NEMT claims in compliance with the requirements of Sections A.15.3 and A.15.4, of ATTACHMENT XI, of the CRA for all months in calendar year 2021.

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 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 shall be processed and paid within twenty-one (21) calendar days of receipt.

Prompt pay testing determined that nursing facility and CHOICES HCBS claims were processed in compliance with Section A.2.22.4 of the CRA for all months in 2021.

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 ECF CHOICES claims for services submitted electronically in a HIPAA-compliant format:

- Ninety percent (90%) of clean claims for ECF CHOICES 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 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	Clean Claims Within 21 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2021	100%	100.0%	**Yes**
February 2021	88%	100.0%	**No**
March 2021	100%	100.0%	**Yes**
April 2021	100%	100.0%	**Yes**
May 2021	100%	100.0%	**Yes**
June 2021	99%	100.0%	**Yes**
July 2021	87%	100.0%	**No**
August 2021	100%	99.7%	**Yes**
September 2021	94%	100.0%	**Yes**
October 2021	99%	99.7%	**Yes**
November 2021	98%	100.0%	**Yes**
December 2021	84%	100.0%	**No**

Prompt pay testing determined that ECF CHOICES HCBS claims were not processed in compliance with Section A.2.22.4 of the CRA for the months of February, July and December 2021.

For February 2021, UPRV proactively informed TDCI of the ECF CHOICES failure and indicated corrective actions had been put in place. UPRV indicated there were a higher percentage of claims requiring manual review and new provider validation. An internal process was implemented to prevent the issue from recurring.

For July 2021, UPRV proactively informed TDCI of their ECF CHOICES failure and indicated that the claims management team did not properly monitor and escalate high risk ECF CHOICES HCBS claims inventory. UPRV implemented the following remediation plan:

- Revisions made to work priority
- Guidelines updated to prioritize clean claims
- Training on revisions and updated guidelines.

For December 2021, UPRV proactively informed TDCI of their ECF CHOICES failure and indicated that per the established inventory management process, the claims were assigned to an auditor responsible for identifying any outstanding inventory. However, the auditor failed to identify the outstanding ECF CHOICES claims. UPRV enhanced the remediation plan to include the following:

- Retrained claims management team on guidelines for escalating high risk claims inventory
- Improved the documentation process
- Increased reporting and overview of high-risk claims inventory

Management Comments

Management concurs.

Prompt Pay Results for CoverKids Claims

UPRV is required to separately comply with the following prompt pay claims processing requirements for CoverKids for Medical and March Vision claims for services submitted electronically in a HIPAA-compliant format:

- Ninety percent (90%) of clean claims for CoverKids shall be processed and paid within thirty (30) calendar days of receipt.

- Ninety-nine-point five percent (99.5%) of clean claims for CoverKids shall be processed and paid within sixty (60) calendar days of receipt.

Prompt pay testing by TDCI determined that CoverKids claims were processed in compliance with the requirements of Tenn. Code Ann. § 56-32-126(b)(1) for all months in 2021.

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.

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 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 February 2021 for ECF CHOICES claims in the West Tennessee Region which reported 95%.

UPRV submitted a corrective action plan which indicated that the failure was due to UPRV incorrectly loading the wrong agreement information for one ECF provider resulting in incorrect claim payments. The ECF provider agreement information was corrected, and claims were reprocessed.

Management Comments

Management concurs.

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, performed the audit and reported compliance with monthly claims payment accuracy requirements for all months in calendar year 2021.

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 and Tennessee Carriers, to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy reports. The review included verification that the number of claims selected by 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 December 2021 claims payment accuracy reports by UPRV, March Vision, and Tennessee Carriers, TDCI selected for verification all 4 medical claims reported as errors and judgmentally selected 20 claims reported as accurately processed by UPRV (10 medical, 5 vision, and 5 NEMT). TDCI retested these claims to the attributes required in Section A.2.22.6.4 of the CRA. For claims that were reported as errors by UPRV, testing by TDCI focused on the type of error (manual or system) and whether the claim was reprocessed.

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

For the 20 claims selected for verification from claims payment accuracy reports prepared by UPRV and the subcontractors for NEMT and vision, no deficiencies were noted by TDCI. TDCI's reverification of the four claims reported as errors determined the claims were properly reprocessed.

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 2021, TDCI judgmentally selected 25 claims per Grand Region as well as 25 CoverKids claims from the data files submitted by UPRV for prompt pay testing purposes. The focused areas for testing during calendar year 2021 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
- Paid and denied CoverKids 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 1,175 claims tested for the calendar year 2021, UPRV reported at least one attribute error on 96 claims. It should be noted a claim may fail more than one attribute. For the 96 claims, 177 attribute errors were reported by UPRV. The following table summarizes the focused claims testing errors reported by UPRV for the calendar year 2021:

Attribute Tested	Errors Reported by UPRV
Data Entry is Verified with Hardcopy Claim	3
Correct provider is Associated to the Claim	2
Authorization Requirements Properly Considered	44
Member Eligibility Correctly Considered	12
Payment Agrees to Provider Contracted Rate	9
Duplicate Payment Has Not Occurred	3
Denial Reason Communicated to Provider Appropriate	80
Copayment Requirements Correctly Considered	2
Modifier Codes Correctly Considered	9
Other Insurance Properly Considered	9
Application of Benefit Limits Considered	4
Total	177

For the 96 claims that contained attribute errors, UPRV identified 38 that were the result of system errors and 58 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.

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. During the review of focused claims testing results, TDCI noted twenty-five (25) additional claims processing deficiencies that resulted in the reprocessing of 12,285 claims with billed charges of $8,746,705. Details of the additional deficiencies are described in this report. The following represents the additional items noted by TDCI during monthly focused testing for calendar year 2021:

   a. Authorization Issues

      1. For the January 2021 focused claims testing, one claim was incorrectly denied by the claims processing system for only one service allowed per month; however, the provider was contracted to provide the services daily. A total of 283 claims were impacted by this error with total billed charges $22,640.00 and the claims have been reprocessed.

      2. For the February 2021 focused claims testing, one claim was incorrectly denied because the claims processing system was not updated to allow payment for inpatient behavioral health services when submitted with a pregnancy-related primary diagnosis. The claims system was updated for the configuration error. A total of 21 claims were impacted with total billed charges of $280,817.28 and all claims have been reprocessed.

      3. For the September 2021 focused claims testing, one claim was incorrectly denied because the claims processing system was set up in

error to require an authorization for physician visits in the nursing facility. The claims processing system was updated for the configuration error. A total of 353 claims were impacted by this error with total billed charges of $68,284.62 and all claims have been reprocessed.

4. For the October 2021 focused claims testing, a claim was incorrectly denied for no prior authorization obtained. The claim was denied manually based upon a standard operating procedure; however, the standard operating procedure was not clear and as a result, the examiner denied the services in error. The standard operating procedure was updated. Fifty-nine (59) additional claims with billed charges of $1,391,140.90 were impacted by this error and all claims have been reprocessed.

5. For the October 2021 focused claims testing, a claim was incorrectly denied by the claims processing system for no prior authorization obtained for a surgery in an office setting. The claims system was updated. An additional 41 claims were impacted by this error with total billed charges of $46,745.92 and all claims have been reprocessed.

6. For the November and December 2021 focused claims testing, UPRV indicated for three claims, the claims processors did not follow standard operating procedures for validating the authorizations and allowed the claims to deny in error. A total of nine claims with billed charges of $168,225.59 were impacted by this error and all claims were reprocessed.

b. Provider Record Issues

1. For the April 2021 focused claims testing, a CoverKids claim was incorrectly denied by the claims processing system as provider not contracted. UPRV indicated the provider was contracted; however, the provider contract was incorrectly configured in the system. The claims system was updated. Forty-one (41) additional claims with billed charges of $3,200.00 were impacted by this error and all claims have been reprocessed.

2. For the May 2021 focused claims testing, a claim was incorrectly denied by the claims processing system as service is not contracted because the provider record had been incorrectly terminated. The claims system was updated. A total of 424 claims with billed charges of $29,475 were impacted by this error and all claims have been reprocessed.

3. For the May 2021 focused claims testing, a claim was incorrectly denied by the claims processing system as service is not contracted because the provider’s record was set up incorrectly in the claims system. The

claim system was updated. A total of 101 claims with billed charges of $16,711 were impacted by this error all claims have been reprocessed.

4. For the May 2021 focused claims testing, a CoverKids claim was incorrectly denied by the claims processing system as service is not contracted because the provider's record was set up incorrectly in the claims system. The claims system was updated. An additional 179 claims with billed charges of $98,253 were impacted by this error and all claims have been reprocessed.

5. For the June 2021 focused claims testing, a CoverKids claim was incorrectly denied by the claims processing system as service is not contracted because the provider's record was set up incorrectly in the claims system. The claims system was updated. An additional 72 claims were impacted by this error with total billed charges of $40,396.25 and all claims have been reprocessed.

6. For the July 2021 focused claims testing, a claim paid incorrectly because the negotiated rate had not been correctly loaded in the provider's record in the claims processing system. The claims system was corrected. A total of 675 claims with billed charges of $683,780.63 were impacted by this error and UPRV indicated all claims have been reprocessed.

7. For the September 2021 focused claims testing, three claims were incorrectly denied by the claims processing system as service is not contracted because the providers' records were set up incorrectly in the claims system. The claims system was updated. An additional 1,790 claims were impacted by this error with total billed charges of $636,458.04 and all claims have been reprocessed.

8. For the September 2021 focused claims testing, a CoverKids claim service line was incorrectly denied as a terminated covered service because the provider's record was set up incorrectly in the claims processing system. The claims system was updated. A total of 42 claims were impacted by this error with total billed charges of $14,070.36 and all claims have been reprocessed.

9. For the October 2021 focused claims testing, a claim was incorrectly denied since the provider validation file from the State was not loaded to the claims processing system appropriately. This caused a delay in the most accurate information being available for claims processing. The claims system was updated. A total of 3,180 claims with billed charges of $2,037,104.92 were impacted by this error and all claims have been reprocessed.

10. For the December 2021 focused claims testing, a claim was incorrectly denied by the claims processing system as service is not contracted because the provider's record was set up incorrectly in the claims system. The claims system was updated. A total of 4,271 claims with billed charges of $734,726.50 were impacted by this error. UPRV indicated all claims have been reprocessed.

c. System Coding Issues

1. For both February and March 2021, two CoverKids claims incorrectly denied by the claims processing system for diagnosis not present on admission because the claims system configuration was not properly updated. The claims system configuration was updated. A total of 66 claims was impacted by this error with billed charges totaling $559,225.88 and UPRV indicated all claims have been reprocessed.

2. For the March 2021 focused claims testing, a CoverKids claim was incorrectly processed by the claims processing system with zero dollars paid because manual intervention was required for the pricing of COVID testing services. A prepayment audit process has been established to identify these errors. An additional 85 claims were impacted by this error with billed charges totaling $49,715.65 and UPRV indicated all claims have been reprocessed.

3. For the April 2021 focused claims testing, a copay was incorrectly applied to a CoverKids claim because the claims processing system was not updated for exempt emergency diagnosis codes. There were 3 claims impacted by this error with $5,192.00 total billed charges and the claims were reprocessed.

4. For the May 2021 focused claims testing, a copay was not correctly applied to a CoverKids claim because the claims processing system was not updated to apply copays for an inpatient facility revenue code. A total of 3 claims were impacted with total billed charges $6,500.00 and the claims were reprocessed.

d. Additional Claims Processing Issues

1. For the March 2021 focused claims testing, the denial reason communicated to the provider for a CoverKids claim was incorrect based upon analysis of the Medicare explanation of benefits. UPRV updated standard operating procedures for reviewing the primary carrier's explanation of benefits to ensure the appropriate explanation reason is communicated to providers for this issue. Eight (8) additional claims

were impacted by this error with total billed charges $13,676.00 and all claims were reprocessed.

2. For the July 2021 focused claims testing, a claim was overpaid because the claims processor did not follow standard operating procedures for applying pricing methodology for physical therapy services. A total of 414 claims with billed charges of $101,941.50 were impacted by this error and all claims were reprocessed.

3. For the November 2021 focused claims testing, a claim was processed with an incorrect received date. The claim was reprocessed to correct the received date. Additional review by UPRV determined a system error occurred. UPRV implemented an enhancement to the processes for corrected claims and adjustment requests. That implementation inadvertently failed to identify and route a particular population of these requests. UPRV corrected the system issue and identified 165 impacted claims with $1,738,423.69 billed charges and UPRV indicated all claims were reprocessed.

Management Comments

Management concurs.

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 45 claims for testing in which no errors were reported by UPRV.

- TDCI judgmentally selected 27 claims for testing in which UPRV reported errors.

No deficiencies were noted by TDCI during the reverification of 45 focused claims testing results.

All 27 claims that UPRV reported as inaccurately processed were properly corrected by UPRV.

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, 2021. From the listing, five enrollees were judgmentally selected. The claims processed for the five enrollees in calendar year 2021 were analyzed to determine if UPRV had correctly applied copayment requirements of the CRA based upon the enrollees' eligibility status.

For three of the five enrollees selected for copayment testing, the following errors were discovered:

1. For one enrollee, UPRV did not correctly apply a copayment for a PCP visit. UPRV applied a $20 copayment; however, a $15 copayment should have been applied to the enrollee's claim based upon the enrollee's eligibility status.

2. For one enrollee, UPRV did not correctly apply a copayment for a specialist visit. UPRV applied a $15 copayment; however, a $20 copayment should have been applied to the enrollee's claim based upon the enrollee's eligibility status.

3. For one enrollee, UPRV did not apply a copayment for a specialist visit. However, a $20 copayment should have been applied to the enrollee's claim based upon the enrollee's eligibility status.

Management Comments

Management concurs.

F. Remittance Advice Testing

The purpose of remittance advice testing was to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system. TDCI requested and UPRV provided 45 remittance advices related to claims previously tested by TDCI. 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 cancelled checks or EFT documentation related to the 45 claims previously tested by TDCI. UPRV provided proof of EFT for all 45

claims. 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, 2022, 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 2,029 claims exceeding 60 days in process. UPRV, including subcontractors, processed 592,967 initial submission claims for the month of July 2022. No material liability exists for claims over 60 days old.

The pended and unpaid CoverKids data files submitted to TDCI as of July 31, 2022, were reviewed for claims which were unprocessed and exceeded 60 days old from receipt date. The CoverKids pended and unpaid data file of claims unprocessed by UPRV, as well as subcontractors, indicate a total of 34 claims exceeding 60 days in process. UPRV's CoverKids, including subcontractor, processed 10,796 initial submission claims for the month of July 2022. No 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 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 2021 provider complaint logs to verify the timeliness of provider reconsideration requests. TDCI judgmentally selected 16 provider reconsideration requests for testing. The selection criteria included provider complaints with processing lags of less than 30 days, between 30 and 60 days, and greater than 60 days. For the sixteen provider complaints selected 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 procedures. No issues were noted in provider complaint procedures. The 16 provider considerations selected for testing were responded to in a timely manner in accordance with Tenn. Code Ann. § 56-32-126(b)(2)(A).

The following deficiencies were noted for 16 provider considerations selected for testing:

- A manual error caused a claim to incorrectly deny on initial submission due to missing data. UPRV reprocessed and paid the claim after receipt of the reconsideration request by the provider.

- A manual error caused a claim to incorrectly deny on initial submission for no prior authorization obtained. UPRV reprocessed and paid the claim after receipt of the reconsideration request by the provider.

Management Comments

Management concurs.

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 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, 2021, TDCI received and processed 117 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	51
Previous denial or payment upheld	54
Previous denial or underpayment partially reversed in favor of the provider	4
Resolved	4
Duplicate	2
Ineligible	2

TDCI judgmentally selected 20 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.

Deficiencies were noted during the review of UPRV’s provider complaint review processes.

- Eight claims denied incorrectly on initial submission due to manual processing errors. For six of the eight manual errors, UPRV provider

complaint procedures failed to identify the errors and overturn the denials before they were submitted to TDCI as a provider complaint.

- Two claims were denied incorrectly on initial submission due to configuration errors in the claims processing system. UPRV provider complaint procedures failed to identify the errors and overturn the denials before they were submitted to TDCI as a provider complaint.

- UPRV upheld the denial based upon medical review for three provider complaints submitted for consideration to UPRV. The provider complaints were overturned by UPRV after submission by the provider to TDCI as a provider complaint. UPRV utilized different medical standards when the complaint was first submitted to UPRV versus when the complaint was submitted to TDCI. The medical standards utilized by UPRV should be consistent during review by UPRV upon receipt as a provider complaint and after the complaints are received by TDCI.

Management Comments

Management concurs.

C. Independent Reviews

The independent review process was established by Tenn. Code Ann. § 56-32-126(b)(2) to resolve claims disputes when a provider believes a TennCare MCO has partially or totally denied claims incorrectly. TDCI administers the independent review process but does not perform the independent review of the disputed claims. When a request for independent review is received, TDCI determines that the disputed claims are eligible for independent review based on the statutory requirements (i.e., the disputed claims were submitted for independent review within 365 days from the date the MCO first denied the claims). If the claims are eligible, TDCI forwards the claims to a reviewer who is not a state employee or contractor and is independent of the MCO and the provider. The decision of the independent reviewer is binding unless 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, 2021, twenty-five independent reviews were initiated by providers against UPRV. The following is a summary of the reviewer decisions:

Reviewer decision in favor of UPRV	13
Reviewer decision in favor of the provider	1
Reviewer decision partially for the provider and UPRV	2
Settled for the provider	7
Ineligible for independent review	2

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 September 02, 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.)

From the 45 claims tested above in Section VI.D.3., TDCI requested the executed provider agreements for testing. No deficiencies were noted during the review of the provider agreements selected for testing.

F. Provider Payments

Capitation payments to providers were tested during 2021 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 2021 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.

Four 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 subcontracts selected for testing.

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 Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, the Age 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), 121 Stat. 1844, 2209). 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 2022 for the calendar year 2021.

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 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 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 100 enrollee episodes included from final and interim reports issued by UPRV from November 2020 through August 2021. Also, TDCI selected for testing 25 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 from November 2020 through August 2021.

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 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, 2019:

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 August 2019.

2. Prompt pay testing by TDCI determined that ECF CHOICES claims were not processed in compliance with Section A.2.22.4 of the CRA for the months of September and October 2019.

3. 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 nursing facilities claims.

4. 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 2019, UPRV reported at least one attribute error on 149 claims during focused claims testing.

5. During the review of focused claims testing results, TDCI noted the following claims processing system (rather than manual) errors:

    - For the January 2019 focused claims testing, UPRV indicated one claim denied incorrectly for no authorization on file due to a system error. UPRV stated that adult day care services were incorrectly authorized as in-home respite care services.

    - For the January 2019 focused claims testing, UPRV indicated that one claim denied incorrectly for exceeding plan limits. UPRV noted the authorization had not been adjusted for the member's plan of care, which approved services beyond the annual plan limit.

- For the February 2019 focused claims testing, UPRV indicated one claim was denied incorrectly for exceeding the daily plan limit. UPRV stated the authorization failed to account for a procedure modifier code that allows the claim to exceed the daily plan limit.

- For the March 2019 focused claims testing, UPRV indicated that one claim was denied incorrectly for services not contracted. UPRV noted that the provider's status in the claims processing system was incorrectly reported as contract terminated.

- For the May 2019 focused claims testing, UPRV indicated one claim was denied incorrectly for services not contracted. UPRV failed to update the provider's record in the claims processing system.

- For the June 2019 focused claims testing, UPRV indicated one claim denied incorrectly for modifier code inconsistent with procedure. UPRV noted that the claims processing system was inappropriately changed for procedure code combination for some therapy codes.

- For the September 2019 focused claims testing, UPRV indicated one claim denied incorrectly for billing physician is not member's primary care physician (PCP). UPRV noted that the claims processing system was not properly configured to apply exceptions to the PCP requirements.

It was determined that these system errors impacted almost 7,000 claims with billed charges totaling approximately $4.7 million.

Deficiencies B.2, B.3, B.4, and B.5 have been repeated in the current examination.

C. Compliance Deficiencies

1. TDCI noted that 35 of 40 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.

2. Six 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 six executed subcontracts selected for testing had never been

submitted to TDCI and the Division of TennCare for prior approval. The subcontractor, Episource LLC, provides records assembly to support internal resources in the Abortions, Sterilizations and Hysterectomy (ASH) audit. The subcontract should have been prior approved by TDCI and the Division of TennCare.

- One of the six executed subcontracts selected for testing has been submitted to TDCI, however, it has not been approved. The subcontractor, Epic Hearing Health Care, Inc., provides hearing aid services, including hearing tests, hearing aid evaluation and applicable follow-up support for the fitment of hearing aids. Epic continues to operate the TennCare line of business without an approved downstream provider agreement. The subcontract should have been prior approved by TDCI and the Division of TennCare before execution.

None of the compliance deficiencies have been repeated in this report.