



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, 2015
THROUGH DECEMBER 31, 2015

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DATE: January 19, 2017

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 September 23, 2016. The report of this examination is herein respectfully submitted.

I. FOREWORD

On March 18, 2016, the TennCare Oversight Division of the Tennessee Department of Commerce and Insurance (TDCI) notified representatives of TennCare operations 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. Fieldwork began on August 8, 2016, and ended on August 19, 2016. All document requests and the signed management representation letter were provided by September 23, 2016.

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 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 TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The financial examination focused on selected balance sheet accounts and the TennCare income statement submitted with its National Association of Insurance Commissioners (NAIC) Annual Statement for the year ending December 31, 2015.

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, 2015, were as follows:

Officers for UPRV

Steven Craig Walli, President, Commercial
Rita Faye Johnson-Mills, President, Medicaid Division
Robert Worth Oberrender, Treasurer
Christina Regina Palme-Krizak, Secretary
James Wesley Kelly, Chief Financial Officer
Nyle Brent Cottingham, Vice President
Charles David Ettelson., Chief Medical Officer
Michelle Marie Huntley, Assistant Secretary

Directors or Trustees for UPRV

Cathie Sue Whiteside	James Edward Hecker
William Kenneth Appelgate, PhD.	Steven Craig Walli
Rita Faye Johnson-Mills	Scott Edward Williams
Charles D. Ettelson	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 TennCare Bureau.

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 TennCare Bureau to receive monthly capitation payments based on the number of enrollees assigned to UPRV and each enrollee's eligibility classification.

For the period January 1, 2015, through December 31, 2015, UPRV received 59% of its nationwide revenue and 69% of its Tennessee revenue from payments for providing TennCare covered services to members. As of December 31, 2015,

UPRV had approximately 477,100 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)
- Non-emergency transportation services

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, 2015, UPRV had approximately 70,800 Medicare enrollees in Tennessee.

C. Claims Processing Not Performed by UPRV

During the period under examination, UPRV subcontracted with March Vision Care Group, Inc., for vision benefits and the processing and payment of related claims submitted by vision providers.

Because the TennCare Bureau 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. 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.

(See Section V.E. of this report)

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.

(See Section VI. A of this report)

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.

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

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.

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

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.

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

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

- 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.
- 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 claims testing.

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

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

- 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.
- 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.
- Multiple paid claims were not successfully submitted to TennCare as encounter data because the claims failed the TennCare Bureau’s claims compliancy edit checks. Encounter data for all paid claims must be submitted to TennCare.

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

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:

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

- 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.

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

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.

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

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

- For two enrollees, UPRV incorrectly applied a copayment of \$15 for several physician specialist visits instead of applying a \$20 copayment per CRA requirements.
- 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.
- For two enrollees, UPRV did not apply a \$50 copayment per CRA requirements for emergency room visits.

(See Section VI.E. 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, 2015, UPRV reported \$1,131,070,715 in admitted assets, \$707,765,179 in liabilities and \$423,305,536 in capital and surplus on the 2015 Annual Statement submitted March 1, 2016. UPRV reported total net income of \$62,453,637 on the statement of revenue and expenses. The 2015 Annual Statement and other financial reports submitted by UPRV can be found at <http://tn.gov/commerce/article/tncoversight-managed-care-organization-financial-reports>.

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, 2016, 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, 2015, 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, 2015, reported capital and surplus to the Company Action Level requirements:

Reported Capital and Surplus	\$ 423,305,536
Reported Authorized Control Level Risk-Based Capital	\$ 94,772,725
Computed and Required Company Action Level Risk-Based Capital (200% of Authorized Control Level)	\$ 189,545,450

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 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, 2015, 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, 2015, or (2) the total cash payments made to UPRV by the TennCare Bureau plus premium revenue earned from non-TennCare operations for the period ending December 31, 2015.

- (1) For the period ending December 31, 2015, UPRV reported total company premium revenues of \$3,421,213,401, on the 2015 NAIC Annual Statement.
- (2) For the period ending December 31, 2015, UPRV received total payments from the TennCare Bureau of \$2,024,327,096, and premium revenue from non-TennCare operations of \$1,416,407,965, for a total of \$3,440,735,061.

Utilizing \$3,440,735,061 as the premium revenue base, UPRV’s minimum net worth requirement as of December 31, 2015 is \$55,361,026 ($\$150,000,000 \times 4\% + (\$3,440,735,061 - \$150,000,000) \times 1.5\%$). UPRV’s reported net worth at December 31, 2015, was \$367,944,510 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 adjusted to include total payments from the TennCare Bureau; the premium revenue base is \$2,924,016,377. UPRV's calculated restricted deposit requirement as of December 31, 2015, is \$15,850,000. As of December 31, 2015, UPRV had on file with TDCI, a depository agreement and properly pledged safekeeping receipts totaling \$44,100,000 to satisfy restricted deposit requirements.

3. Claims Payable

UPRV reported \$295,742,897 claims unpaid as of December 31, 2015. Of the total claims unpaid reported, \$167,777,112 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, 2016, for dates of services before January 1, 2016, 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, 2015, UPRV's TennCare Operating Statement reported Total Revenues of \$2,004,805,436, Medical Expenses of \$1,564,607,361, Administrative Expenses of \$362,970,406, Income Tax Expense of \$40,892,048, and Net Income of \$36,335,622.

No reportable deficiencies were noted in the preparation of the TennCare Operating Statements for the period ending December 31, 2015. The TennCare Operating Statements are separate schedules in the UPRV 2015 NAIC Annual Statement which can be found at <http://tn.gov/commerce/article/tnoversight-managed-care-organization-financial-reports>.

C. Medical Loss Ratio Report

Section A.2.30.16.2.1 of the CRA requires:

The CONTRACTOR shall submit a Medical Loss Ratio Report monthly with cumulative year to date calculation. The CONTRACTOR shall report all medical expenses and complete the supporting claims lag tables. This report shall be accompanied by a letter from an actuary, who may be an

employee of the CONTRACTOR, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy. The CONTRACTOR shall also file this report with its NAIC filings due in March and August of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report shall reconcile to NAIC filings including the supplemental TennCare income statement. The CONTRACTOR shall also reconcile the amount paid reported on the supporting claims lag tables to the amount paid for the corresponding period as reported on the CONTRACTOR's encounter file submission as specified in Sections A.2.30.18.3 and A.2.23.4.

UPRV submits medical loss ratio (MLR) reports for each region on the basis of the State's fiscal year which ends on June 30. The medical loss ratio percentage is based upon total medical payments plus incurred but not reported (IBNR) claims estimate divided by capitation revenue net of premium tax. TDCI performs an analysis of each region and for all regions combined. UPRV's MLRs for the period July 1, 2015, through December 31, 2015, were submitted January 20, 2016. Based on TDCI's analysis, the combined medical loss ratio with capitation revenue net of premium tax was 87.58% for this period. UPRV's July 2016 MLRs were submitted on August 19, 2016. Based on an analysis of UPRV's July 2016 MLRs, for the period July 1, 2015, through December 31, 2015, the combined medical loss ratio was 86.02%. 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, 2015, UPRV reported total Administrative Expenses of \$533,919,537 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 15.6% 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 TennCare Bureau. The allocation methodologies utilized by UPRV to determine administrative expenses were reviewed by TDCI. No deficiencies were noted during the review of the management agreement.

E. Supplemental Compensation Exhibit

UPRV must file with its state of domicile and any state that requests it in writing a Supplemental Compensation Exhibit for the principal executive officer, principal financial officer, the three most highly compensated executive officers and the next five most highly compensated employees whose individual total compensation exceeds \$100,000. Since UPRV is part of a holding company system the exhibit may also report amounts paid to officers and employees of more than one insurer in the group or system either on a total gross basis or by allocation to each insurer.

Compensation shall consist of any and all remuneration paid to or on behalf of an officer, employee, or director covered by this requirement, including, but not limited to, wages, salaries, bonuses, commissions, stock grants, gains from the exercise of stock options, and any other emolument.

TDCI selected for testing the chief executive officer and the chief financial officer reported compensation for calendar year 2015.

UPRV provided the following explanation for the allocation methodology utilized for the Supplemental Compensation Exhibit as follows: "The allocation method we use takes the director/officer total compensation divided by the total number of director positions across UHG [UnitedHealth Group] times the number of director positions for that specific legal entity. ... The rationale is that if a person has more titles on a

legal entity (e.g. CEO, President and Director) then they have more responsibilities and should in theory receive more compensation.”

Based on the allocation methodology utilized, UPRV reported for both the chief executive officer and the chief financial officer only 33% of their total compensation on the 2015 Supplement Compensation Exhibit. Both employees indicated that they spend in excess of 95% of their time dedicated to UPRV. When an officer serves as a director for multiple UHG entities, the allocation method based upon time dedicated to each entity provides a more representative presentation. The allocation utilized by UPRV materially understates the compensation for the employees tested. The Supplemental Compensation Exhibit may be found at <http://www.tn.gov/commerce/article/tncoversight-4q2015>.

Management Comments

UPRV would clarify the statement that the supplemental compensation exhibit for “both the chief executive officer and the chief financial officer only 33% of their total compensation.” Due to the methodology by which UPRV allocated compensation in this exhibit, only the chief executive officer’s compensation was shown at 33%. It was shown at this level due to the multiple directorships that director held in 2015.

Insurers that are part of a group of insurers or other holding company system may file amounts paid to officers and employees of more than one insurer in the group or system either on a total gross basis or by allocation to each insurer. In future submissions, the exhibit will be prepared in accordance with the recommendation by TDCI to further define the allocation by percentage of time.

F. Schedule of Examination Adjustments to Capital and Surplus

No adjustments are recommended to Capital and Surplus for the period ending December 31, 2015, 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, and March Vision, the vision subcontractor.

UPRV All TennCare Operations	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2015	100%	100.0%	Yes
February 2015	100%	100.0%	Yes
March 2015	100%	100.0%	Yes
April 2015	100%	99.9%	Yes
May 2015	99%	100.0%	Yes
June 2015	100%	99.9%	Yes
July 2015	100%	100.0%	Yes
August 2015	100%	100.0%	Yes
September 2015	99%	99.5%	Yes
October 2015	100%	100.0%	Yes
November 2015	100%	100.0%	Yes
December 2015	100%	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 2015.

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 2015.

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 is in compliance with the requirements of Section A. 15.3 and A.15.4, of ATTACHMENT XI of the CRA for all months in calendar year 2015.

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

CHOICES	Clean claims Within 14 days	All claims Within 21 days	Compliance
T.C.A. Requirement	90%	99.5%	
hJanuary 2015	89%	97.1%	No
eFebruary 2015	87%	95.5%	No
cMarch 2015	96%	99.7%	Yes
April 2015	82%	95.4%	No
May 2015	96%	99.3%	No
June 2015	96%	99.5%	Yes
July 2015	99%	99.8%	Yes
August 2015	99%	99.9%	Yes
September 2015	99%	99.8%	Yes
October 2015	100%	100.0%	Yes
November 2015	100%	99.9%	Yes
December 2015	99%	99.9%	Yes

UPRV was in compliance with Section A.2.22.4 of the Contract requirements for timely processing of CHOICES claims for June through December 2015, but failed to achieve compliance in the months of January, February, April and May 2015. Corrective Action Plans were requested and provided by UPRV. The failures related mainly to two claims processing system issues.

- Claims were inappropriately rejected based on NPI requirements.
- Medicare/Medicaid Dual Enrollment claims were inappropriately processed based on coordination of benefit requirements.

Management Comment

Management Concur. We have taken action to correct these matters, including updating and testing our claims payment system, reprocessing claims which were rejected inappropriately, validating 100% of the provider data loading relative to the inappropriately rejected claims, updating applicable standard operating procedures, and implementing focused reviews of claim adjudication accuracy prior to daily check runs.

The complete results of TDCI's prompt pay compliance testing can be found at <http://www.tn.gov/commerce/article/tncoversight-prompt-pay-compliance-reports>.

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

As noted below, TDCI discovered deficiencies related to 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 TennCare Bureau. 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 2015 for the following regions, months, and claim types:

East Tennessee Region

Month of Filing	Claim Type	Percentage Reported
February 2015	Nursing Facility	94%
March 2015	Nursing Facility	95%
April 2015	Nursing Facility	93%
May 2015	Medical	96%
June 2015	Medical	93%
August 2015	Medical	93%
September 2015	Medical	94%
September 2015	Nursing Facility	92%

Middle Tennessee Region

Month of Filing	Claim Type	Percentage Reported
March 2015	Medical	95%
March 2015	Nursing Facility	93%
June 2015	Medical	94%
August 2015	Medical	93%
October 2015	Medical	93%
November 2015	Medical	93%
December 2015	Medical	95%

West Tennessee Region

Month of Filing	Claim Type	Percentage Reported
March 2015	Nursing Facility	94%

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. TDCI and the TennCare Bureau were concerned about the significant failures noted in monthly claims payment accuracy percentages. During calendar year 2015 TDCI met with UPRV's executive staff and relayed TDCI's concerns. UPRV has provided TDCI and the TennCare Bureau initiatives and processes to improve claims payment accuracy. Additionally, during 2015 the TennCare Bureau assessed UPRV \$115,000 in liquated damages related to claims payment accuracy failures for medical and nursing facility claim types.

Management Comments

Management Concur. We have taken action to correct these matters including correcting identified defects and adjusting impacted claims, providing coaching and feedback to claims processors, auditing 100% of our facility provider contract load for accuracy, implementing dedicated facility provider contract loading staff and auditors, and reviewing/updating standard operating procedures as appropriate.

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. UPRV failed to achieve the contractual requirement of 97% claims payment accuracy for NEMT for the months in 2015 as noted in the chart above.

Month of Filing	Region	Percentage Reported
July 2015	East Tennessee	91%
August 2015	East Tennessee	94%
September 2015	East Tennessee	96%
October 2015	East Tennessee	83%
June 2015	Middle Tennessee	88%
August 2015	Middle Tennessee	96%
October 2015	Middle Tennessee	93%
February 2015	West Tennessee	95%
October 2015	West Tennessee	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. As noted above with medical and nursing facility failures, TDCI and the TennCare Bureau were concerned about the significant failures noted in monthly claims payment accuracy percentages. During 2015 the TennCare Bureau assessed UPRV \$190,000 in liquated damages related to claims payment accuracy failures for NEMT claim types.

Management Comments

Management Concur. We have taken action to correct these matters including correcting identified defects and adjusting impacted claims, providing coaching and feedback to claims processors and reviewing/updating standard operating procedures as appropriate.

3. Procedures to Review the Claims Payment Accuracy Reports

The review of the claims payment accuracy reports included an interview with responsible staff of UPRV 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 agreed to requirements of Sections 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 2015 claims payment accuracy reports, TDCI selected for verification twenty claims reported as errors and twenty 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

For the claims selected for verification from UPRV's claims payment accuracy reports, the following deficiencies were noted:

- 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. UPRV should develop controls to ensure that claims identified as errors during the claims payment accuracy testing are corrected in a timely manner.
- One of the twenty claims TDCI tested was determined by UPRV as 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.

Management Comments

Management Concur. We have taken action to correct these matters including adjusting the inaccurately processed claim and reviewing the testing. Since the UPRV Market Conduct Exam, we have located additional documentation which demonstrates that our initial testing of the claim that paid according to the provider agreement was accurate. We are committed to improving the replication of our testing during future market conduct exams.

D. Focused Claims Testing

Effective January 1, 2012, the CRA included additional monthly focused claims testing requirements that require UPRV to self-test the accuracy of claims processing based on claims selected by TDCI. Unlike random sampling utilized in the claims payment accuracy reporting, claims related to known claims processing issues or claims involving complex processing rules are judgmentally selected for the focused claims testing. Any results reported from focused claims testing are not intended to represent the percentage of compliance or non-compliance for the total population of claims processed by UPRV.

The focused claims testing results highlights or identifies claims processing issues for improvement. For examination purposes, TDCI utilized the results of the focused claims testing to evaluate the accuracy of the claims processing system.

For monthly focused claims testing by UPRV during calendar year 2015, 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 2015 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

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 2015, UPRV reported at least one attribute error on 214 claims. It should be noted a claim may fail more than one attribute. For the 214 claims, 360 attribute errors were reported by UPRV. The following table summarizes the focused claims testing errors reported by UPRV for the calendar year 2015:

Attribute Tested	Errors Reported by UPRV
Data Entry is Verified with Hardcopy Claim	1
Correct provider is Associated to the Claim	12
Authorization Requirements Properly Considered	65
Member Eligibility Correctly Considered	4
Payment Agrees to Provider Contracted Rate	19
Duplicate Payment Has Not Occurred	2
Authorization Requirements Properly Considered	1
Denial Reason Communicated to Provider Appropriate	211
Modifier Codes Correctly Considered	27
Other Insurance Properly Considered	3
Patient Liability Correctly Applied	0
Coding-Bundling/Unbundling Properly Considered	0
Application of Benefit Limits Considered	13
Considered Benefit Limit HCBS Provided as Cost Effective Alternative	3
Total	360

For the 214 claims that contained attribute errors, UPRV identified 42 that were the result of system errors and 172 that were the result of manual errors. For the system errors, UPRV provided explanation 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.

2. Additional Deficiencies Noted by TDCI During Focused Claims Testing

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

a. Vague Denial Reasons:

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. This finding is repeated from the previous examination report.

Management Comments

Management Concur. In the review of this matter, we determined that our responses to TDCI Focused Claims Testing inquiries only included denial

reasons which are internal to our claims payment system and not include the denial reasons that are shared with providers. For provider messaging of denial reasons on remittance advices, we utilize Industry Standard Washington Publishing Company description codes. We have taken action to correct this matter by including the denial reasons that are communicated to providers on remittance advices in our Focused Claims Testing responses.

b. Retroactive Eligibility

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. This finding is repeated from the previous examination report.

Management Comments

Management Concur. We have taken action to correct this matter by implementing a process to review members with retro-eligibility and processing claims accordingly.

c. Encounter Data Issues:

Multiple paid claims were not successfully submitted to TennCare as encounter data because the claims failed the TennCare Bureau's claims compliancy edit checks. Encounter data for all paid claims must be submitted to TennCare. This finding is repeated from the previous examination report. UPRV provided information on a series of system enhancements that have been implemented to correct system errors related to compliancy edits.

Management Comments

Management Concur. We are committed to ensuring claims are received, properly adjudicated and successfully encountered to TennCare. We monitor the success of claims that are encountered with TennCare and work to address opportunities as a result of those reviews. We have taken action to correct this matter by updating our claims payment system and implemented EDIFECs edits for noncompliant claims to manage our claims and encounters compliance.

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 36 claims for testing in which no errors were reported by UPRV and,
- 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 36 no error claims selected for testing, TDCI noted the following:
 - TDCI noted during the review of the procedures utilized by UPRV when testing the attribute “Payment agrees to provider contracted rate”, 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 adjudicated payment to the contracted fee schedule.
 - One of the 36 claims 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 to render a covered service. The submitted document did not report a date of service since no service had been 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.
 - One of the 36 claims 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.

Management Comments

Management Concur. We have taken action to correct the matters including updating our standard operating procedure and began reviewing

claims adjudication against the contracted fee schedule for our Focused Claims Testing in June, 2016 and informing the state of the change in other insurance status so that it can be updated and reported accordingly.

- b. During the review of the 25 claims in which UPRV reported processing errors, TDCI noted one of the claims was still not corrected by UPRV as of the August 2016 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 Concur. We took action to correct this matter by updating our claims payment system, adjusting the claim and enhancing our oversight of the correction of identified claims errors.

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, 2015. From the listing, five copayment amounts were judgmentally selected and all of the claims processed for those enrollees in calendar year 2015 were analyzed to determine if UPRV had correctly applied copayment requirements of the CRA based upon the enrollees' eligibility status. The following deficiencies were noted:

- o For two enrollees, UPRV incorrectly applied a copayment of \$15 for several physician specialist visits instead of applying a \$20 copayment per CRA requirements.
- o 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.
- o For two enrollees, UPRV did not apply a \$50 copayment per CRA requirements for emergency room visits.

Management Comments

Management Concur. We have taken action to correct the matter by updating our claims payment system configuration to apply appropriate copayment amounts as well as by developing a process to review copayment amounts applied to PCP services prior to final claims adjudication.

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 thirteen 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, 2016, 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 2,538 claims exceeding 60 days in process. 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 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.

UPRV maintains two provider complaint logs. One log tracks provider complaints received via the TennCare Bureau and TDCI, while a separate log tracks provider complaints received through UPRV's claims processing department. TDCI reviewed twenty provider complaints from the 2015 TennCare Bureau and TDCI provider complaint log and five provider complaints from the December 2015 UPRV claims processing department provider complaint log. No deficiencies were noted in the processing of provider complaints in accordance with timeliness requirements of Tenn. Code Ann. § 56-32-126(b)(2)(A).

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 2015, the MCO was required to respond in writing within 14 days to both the provider and TDCI to avoid assessment of

liquidated damages pursuant to the "On Request" report requirements of the CRA.

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

For the period January 1 through December 31, 2015, TDCI received and processed 391 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	172
Previous denial or payment upheld	160
Previous denial or underpayment partially reversed in favor of the provider	25
Paid by UPRV upon Receipt of Complaint	6
Other inquiries	26
Ineligible or duplicate	2

TDCI judgmentally selected 25 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 25 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, 2015, 107 independent reviews were initiated by providers against UPRV. The following is a summary of the reviewer decisions:

Reviewer decision in favor of UPRV	39
Reviewer decision in favor of the provider	22
Settled for the provider	9
Previous denial or underpayment partially reversed in favor of the provider	18
Ineligible	8
Rescinded	11

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 five independent reviews selected, 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. A complete revision of the provider manual was approved by TDCI on June 2, 2016.

E. Provider Agreements

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

Per Section 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.

From the 36 claims tested above in Section VI.D., TDCI requested the executed provider agreements for testing. No discrepancies were noted during the review of the provider agreements.

F. Provider Payments

Capitation payments to providers were tested during 2015 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 2015 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) that the contract templates were prior approved by TDCI and the TennCare Bureau and (2) that the executed agreements were on approved templates.

No discrepancies were noted during the review of the subcontract agreements.

H. Subcontractor Monitoring

The CRA between UPRV and the TennCare Bureau 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.2.26.7 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 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 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.2.22.6.2 of the CRAs 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 Bureau 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 2016 for the calendar year 2015.

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, 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 and 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 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 material instances of non-compliance with conflict of interest requirements for UPRV during the examination test work.

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, 2013:

A. Financial Deficiencies

Administrative costs are incorrectly reported as medical costs in the determination of medical loss percentages.

B. Claims Processing Deficiencies

1. UPRV failed to achieve the monthly claims payment accuracy requirement of 97% as required by Section 2.22.6 of the CRAs for the following months and claim types: East Tennessee Medical for the month of October 2013, East Tennessee Long-term Care for the month of September 2013, Middle Tennessee Long-term Care for the month of November 2013 and West Tennessee Long-term Care for the month of November 2013.
2. The review of UPRV's claims payment accuracy reporting and testing procedures for December 2013 noted the following deficiencies:
 - Section 2.22.6.4.5 of the CRAs requires UPRV to determine if the allowed payment agrees with the contracted rate. UPRV's claims payment accuracy testing procedures do not confirm the allowed payment to the amount defined in the providers' contract for each claim tested.
 - For two of the twenty claims tested, the amount paid by UPRV could not be verified against the reimbursement terms of the provider agreements.
 - For the twenty claims selected for testing, two paid claims were never submitted to TennCare as encounter data as required by Section 2.12.9.34.2 of the CRAs.
3. The CRAs include additional monthly focused claims testing requirements for UPRV to self-test the accuracy of claims processing based on claims selected by TDCI. For the 900 claims tested for calendar year 2013, UPRV reported at least one attribute error on 91 claims.
4. During the review of the errors identified as a result of focused claims testing, TDCI noted the following significant claims processing system issues:

- a. UPRV indicated that two claims were incorrectly denied during the January 2013 focused testing for the same reason. UPRV noted for one claim the system was incorrectly applying claims coding billing rules and the system error had been fixed. For the other claim, UPRV indicated that additional research found that the initial response to the focused testing was incorrect. The claim had been correctly denied for claims coding rules.
 - b. UPRV indicated that three claims incorrectly denied for “submitted after provider’s filing limit”. The members were made retroactively eligible and the claims should have paid. UPRV indicated that the claims have been sent for adjustment.
 - c. UPRV indicated that one claim incorrectly denied with denial reason “Medicaid ID number/disclosure needed”. UPRV indicated that there was a disclosure ID on file and the claim should have paid. The claim was sent for adjustment.
5. During the review of focused claims testing results, TDCI noted the following additional items:
- a. Multiple claims were denied with the only denial reason communicated to the provider being “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. This finding is repeated from the previous examination report.
 - b. UPRV does not submit all paid claims to the TennCare Bureau for encounter data purposes. The following discrepancies were noted:
 - Multiple paid claims were not submitted to TennCare since the claims failed compliancy edits. Encounter data for all paid claims should be submitted to TennCare.
 - Multiple paid claims where another payer or Medicare was the primary insurer were not submitted.
 - c. Significant claims adjudication issues related to CHOICES claims submitted via the separate Electronic Visit Verification system (EVV) were noted by TDCI during the review of UPRV’s monthly focused claims testing.
 - UPRV communicates the procedure code and the modifier to the EVV system based upon the enrollee’s plan of care. The provider has the ability to change the modifier in the EVV system and therefore perform a service not authorized in the enrollee’s plan of care.

- The authorizations granted in UPRV's claims processing system are not always in agreement with the authorizations loaded in the EVV system. As a result of the error, providers are able to provide and bill for services not in agreement with the enrollee's plan of care.
 - For Home and Community Based Services (HCBS) claims, UPRV routinely communicates a second denial reason or explanation to the provider "claim may be covered by COB". This is not an appropriate denial reason since CHOICES HCBS claims would never be covered by other insurance.
 - In completing the attribute test work for the monthly focused claims testing UPRV often indicated adjustments were required to correct a claim, however, illogically UPRV indicated no error was reported for any of the testing attributes.
- d. TDCI noted the following issues in relation to the accuracy of the prompt pay data file submissions from which the samples of claims for focused testing were selected:
- Multiple claims were submitted with a status of "denied" and zero dollars paid; however, the explanation code indicated that the charges have been paid by another payer. UPRV should have marked these as "paid" claims, even though there was no UPRV liability after the primary insurer paid.
 - Multiple claims were incorrectly reported as "paid" or "denied" rather than as "adjusted". UPRV agreed that the claims should have been reported as adjusted.
- e. Multiple claims were denied for "date of service after the subscriber termination". UPRV's claim system assigns a new member number any time a member is reassigned to another Grand Region. The denial reason is inaccurate as the member was never terminated as a TennCare enrollee.
- f. Testing resubmitted claims that were denied for timely filing found that the original claims were denied for missing Medicaid ID/TennCare disclosure. UPRV indicated that, per timely filing standard operating procedures (SOP), if a claim was originally denied for this reason, the timely filing requirement can be overridden when the claim is resubmitted after the appropriate disclosure is made. In violation of UPRV's SOP, the claims tested had continued to be denied in error for exceeding the timely filing limit.

- g. Focused testing revealed that denied service lines of claims processed by the subcontractor, March Vision, were not submitted to TennCare for encounter data purposes.

6. Verification of UPRV Self-reported Focused Testing Results

- a. TDCI noted during the review of the procedures utilized by UPRV when testing the attribute "Payment agrees to provider contracted rate", UPRV does not verify the claim pricing accuracy with payment terms in the executed provider contract.
- b. During the review of the 35 claims for which no errors were reported by UPRV, TDCI could not verify that one claim paid at the correct reimbursement rate because the executed provider agreement could not be located.
- c. During the review of the 91 claims reported by UPRV to have processing errors, TDCI noted 38 of the 91 claims were never reprocessed to correct the errors. UPRV provided the following explanations during fieldwork as to why these claims were not reprocessed:
 - After submitting the focus testing results, UPRV later determined that 24 claims noted as processed in error were in fact processed correctly.
 - Five claims were not reprocessed because there was either no financial impact or the financial impact was immaterial. As a result, the processing errors were not corrected.
 - Nine claims had not been corrected at the time of fieldwork even though UPRV agreed that these claims should have been reprocessed.

UPRV should more carefully review responses to monthly focused claims testing results prior to submission of the report to TDCI. Claims found to be processed in error should be promptly corrected.

7. Copayment test work revealed that UPRV incorrectly applied a \$500 copay to one member. Based on the member's TennCare eligibility status no copay should have been taken for this member.

C. Compliance Deficiencies

1. One provider complaint was resolved in 127 days. Tenn. Code Ann. § 56-32-126(b)(2)(A) requires UPRV to respond to a provider's reconsideration requests within 60 calendar days unless a longer time to completely respond is agreed upon in writing by the provider and the HMO. UPRV did not have a written

agreement with the provider that the resolution of this complaint would take longer than 60 days to complete in violation of Tenn. Code Ann. § 56-32-126(b)(2)(A).

2. The following deficiencies were noted during the testing of provider agreements:
 - Two executed provider agreements were not based on template agreements prior approved by TDCI. These provider agreements had been submitted to and disapproved by TDCI. UPRV should not execute provider agreements on templates not approved by TDCI in violation of TCA § 56-32-103 and CRA section 2.12.2.
 - UPRV resubmitted one of the two executed provider agreements not on prior approved templates; however, TDCI again disapproved it because it failed to meet CRA provider agreement requirements. UPRV has not resubmitted the agreement to TDCI for approval.
3. The following deficiencies were noted during testing of subcontracts:
 - a. UPRV received, as required, prior approval for a subcontract template; however, UPRV executed a version different from the template prior approved by TDCI.
 - b. A subcontractor and affiliate of UPRV further subcontracted with two additional companies to perform subrogation services. The UPRV affiliate did not receive prior written approval from UPRV and the TennCare Bureau before entering into the subcontracts thereby violating Sections 2.26.2, 2.26.3, and 2.26.1.4 of the CRA.

Findings similar to B.1., B.2., B.3., B.4.b., B.5.a, B.5.b., and B.6.a., have been repeated in the current examination.