
# 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, 2019
THROUGH DECEMBER 31, 2019

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DATE: December 11, 2020

The Financial and Compliance Examination and Market Conduct Examination of the TennCare Operations of UnitedHealthcare Plan of the River Valley, Inc., Brentwood, Tennessee, was completed August 31, 2020. The report of this examination is herein respectfully submitted.

## I. FOREWORD

On April 20, 2020, 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 due to the COVID-19 pandemic began on August 17, 2020 and ended on August 28, 2020. All document requests and the signed management representation letter were provided by August 31, 2020.

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, 2019.

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, 2019, were as follows:

Officers for UPRV

Robert Andersen Broomfield, President, Commercial
Keith Christopher Payet, President, Medicaid Division
Peter Marshall Gill, Treasurer
Heather Anastasia Lang, Secretary
James Wesley Kelly, Chief Financial Officer
Nyle Brent Cottington, Vice President
Jessica Leigh Zuba, Assistant Secretary

Directors or Trustees for UPRV

| | |
|---|---|
| Cathie Sue Whiteside | James Edward Hecker |
| William Kenneth Appelgate, PhD. | Robert Andersen Broomfield |
| Brendan Paul Hostetler | Scott Edward Williams |
| James Wesley Kelly | Keith Christopher Payet |

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, 2019, UPRV had approximately 422,000 TennCare members state-wide. The TennCare benefits required to be provided by UPRV are:

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

Effective March 1, 2010, the CRA between 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, 2019, UPRV had approximately 9,600 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, 2019, UPRV had 423 enrollees in the Employment and Community First CHOICES program.

For the period January 1, 2019, through December 31, 2019, UPRV received 42% of its nationwide revenue and 65% of its Tennessee revenue from payments for providing TennCare covered services to members.

In addition to TennCare operations, in January 2008, UPRV began offering a Medicare Advantage Special Needs Plan for those who are eligible for both Medicaid and Medicare. Also, effective January 2011, UPRV received approval from the Centers for Medicare and Medicaid Services to cover traditional Medicare beneficiaries in addition to the existing special needs beneficiaries. For the year ending December 31, 2019, UPRV had approximately 61,500 Medicare enrollees in in Tennessee.

C. Claims Processing Not Performed by UPRV

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

- March Vision Care Group, Inc., for vision benefits and the processing and payment of related claims submitted by vision providers.

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

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

Because the Division of TennCare has contracted with other organizations for the provision of dental and pharmacy benefits, UPRV is not responsible for providing these services to TennCare enrollees.

## IV. SUMMARY OF CURRENT FINDINGS

The summary of current factual findings is set forth below. The details of testing as well as management's comments to each finding can be found in Sections V, VI, and VII of this examination report.

A. Financial Deficiencies

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

B. Claims Processing Deficiencies

1. 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.

   (See Section VI.A. of this report)

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.

   (See Section VI.A. of this report)

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.

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

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.

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

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.

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

   - 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.

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

   - 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.

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

   - 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.

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

   - 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.

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

   - 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.

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

- 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.

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

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

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.

   (See Section VII.E. of this report)

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.

     (See Section VII.G. of this report)

## V. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

### A. Financial Analysis

As an HMO licensed in the State of Tennessee, 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, 2019, UPRV reported $1,110,220,730 in admitted assets, $494,342,193 in liabilities and $615,878,537 in capital and surplus on the 2019 Annual Statement submitted March 1, 2020. UPRV reported total net income of $157,573,036 on the statement of revenue and expenses. The 2019 Annual Statement and other financial reports submitted by UPRV can be found at https://www.tn.gov/commerce/tenncare-oversight/reports/managed-care-organization-financial-reports.html .

1. Capital and Surplus

a. Risk-Based Capital Requirements:

UPRV is required to comply with risk-based capital requirements for health organizations as codified in TCA § 56-46-201 et seq. UPRV has submitted a report of risk-based capital (RBC) levels as of December 31, 2019. 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, 2019, 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, 2019, reported capital and surplus to the Company Action Level requirements:

| | |
|---|---|
| Reported Capital and Surplus | $ 615,878,537 |
| Reported Authorized Control Level Risk-Based Capital | $ 151,834,149 |
| Computed and Required Company Action Level Risk-Based Capital (200% of Authorized Control Level) | $ 303,668,298 |

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, 2019, 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, 2019, 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, 2019.

(1) For the period ending December 31, 2019, UPRV reported total company premium revenues of $4,664,723,254, on the 2019 NAIC Annual Statement (Schedule T total).

(2) For the period ending December 31, 2019, UPRV received total medical payments from the Division of TennCare of $2,223,773,528, and all other premiums and consideration of $2,692,905,977 (Schedule T total premiums less Tennessee Medicaid premiums), for a total of $4,916,679,505.

Utilizing $4,916,679,505 as the premium revenue base, UPRV's minimum net worth requirement as of December 31, 2019 is $77,500,193 ($150,000,000 x 4% + ($4,916,679,505 - 150,000,000) x 1.5%). UPRV's reported net worth at December 31, 2019, was $538,378,344 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 total medical payments from the Division of TennCare of $2,223,773,528, and all other Tennessee premiums and consideration of $1,046,307,004, the premium revenue base is $3,270,080,532. UPRV's calculated restricted deposit requirement as of December 31, 2019, is $17,600,000. As of December 31, 2019, UPRV had on file with TDCI, a depository agreement and properly pledged safekeeping receipts totaling $37,000,000 to satisfy restricted deposit requirements.

3. Claims Payable

UPRV reported $300,477,322 claims unpaid as of December 31, 2019. Of the total claims unpaid reported, $168,052,641 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, 2020, for dates of services before January 1, 2020, 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, 2019, UPRV's TennCare Operating Statement reported Total Revenues of $1,977,365,277, Medical Expenses of $1,595,103,450, Administrative Expenses of $318,383,144, Income Tax Expense of $13,414,523, and Net Income of $50,464,160.

No reportable deficiencies were noted in the preparation of the TennCare Operating Statements for the period ending December 31, 2019. The TennCare Operating Statements are separate schedules in the UPRV 2019 NAIC Annual Statement which can be found at https://www.tn.gov/commerce/tenncare-oversight/reports/managed-care-organization-financial-reports.html .

C. Medical Loss Ratio Report

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

UPRV submits MLR reports for each region on the basis of the State's fiscal year which ends on June 30. The MLR percentage is based upon total medical payments plus the incurred but not reported (IBNR) claims estimate divided by capitation revenue net of premium tax. TDCI performs an analysis of each region and for all regions combined. UPRV's MLRs for the period July 1, 2019, through December 31, 2019, were submitted January 16, 2020. Based on TDCI's analysis, the combined medical loss ratio with capitation revenue net of premium tax was 92.4% for this period. UPRV's July 2020 MLRs were submitted on August 17, 2020. Based on an analysis of UPRV's July 2020 MLRs, for the period July 1, 2019, through December 31, 2019, the combined medical loss ratio was 92.3%. 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 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, 2019, UPRV reported total Administrative Expenses of $306,028,554 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 6.6% 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 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.

For the year ended December 31, 2019, management fees/allocated expenses of $155,900,179 were charged to UPRV by USCRV for TennCare operations. The management fee represented approximately 3.3% 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, 2019, as a result of the examination of UPRV's TennCare operations.

## VI. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

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

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

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

**Prompt Pay Results for All Claims Processed**

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

| **UPRV All TennCare Operations** | Clean claims Within 30 days | All claims Within 60 days | Compliance |
|---|---|---|---|
| T.C.A. Requirement | 90% | 99.5% | |
| January 2019 | 100% | 99.9% | **Yes** |
| February 2019 | 100% | 100.0% | **Yes** |
| March 2019 | 100% | 99.9% | **Yes** |
| April 2019 | 100% | 99.9% | **Yes** |
| May 2019 | 100% | 99.8% | **Yes** |
| June 2019 | 100% | 100.0% | **Yes** |
| July 2019 | 100% | 100.0% | **Yes** |
| August 2019 | 100% | 100.0% | **Yes** |
| September 2019 | 100% | 100.0% | **Yes** |
| October 2019 | 100% | 100.0% | **Yes** |
| November 2019 | 100% | 100.0% | **Yes** |
| December 2019 | 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 2019.

**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 2019.

**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, Inc., processed NEMT claims in compliance with the requirements of Section A.2.22.4, of the CRA for all months in calendar year 2019.

**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 by TDCI determined that nursing facility and CHOICES HCBS claims were processed as reported in the following table:

| **Nursing Facility and CHOICES HCBS** | Clean claims Within 30 days | All claims Within 60 days | Compliance |
|---|---|---|---|
| T.C.A. Requirement | 90% | 99.5% | |
| January 2019 | 100% | 99.9% | **Yes** |
| February 2019 | 99% | 99.6% | **Yes** |
| March 2019 | 100% | 100.0% | **Yes** |
| April 2019 | 100% | 100.0% | **Yes** |
| May 2019 | 99% | 100.0% | **Yes** |
| June 2019 | 100% | 100.0% | **Yes** |
| July 2019 | 97% | 99.8% | **Yes** |
| August 2019 | 87% | 99.9% | **No** |
| September 2019 | 99% | 99.9% | **Yes** |
| October 2019 | 100% | 100.0% | **Yes** |
| November 2019 | 100% | 99.9% | **Yes** |
| December 2019 | 100% | 99.9% | **Yes** |

P

Prompt pay testing determined that nursing facility and CHOICES HCBS claims were not processed in compliance with Section A.2.22.4 of the CRA for the month of August 2019.

UPRV proactively informed TDCI of the CHOICES failure and indicated a corrective action had been put in place. The corrective action indicated a system issue caused the processing of claims for one provider to be delayed. Additional controls were put in place to prevent the system issue from recurring.

Management Comments

Management concurs and remediation is complete.

**Prompt Pay Results for ECF CHOICES HCBS Claims**

Pursuant to Section A.2.22.4.4 of the CRA, UPRV is required to separately comply with the following prompt pay claims processing requirements for Employment and Community First (ECF) CHOICES HCBS claims for services submitted electronically in a HIPAA-compliant format:

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

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

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

| **ECF CHOICES** | Clean claims Within 30 days | All claims Within 60 days | Compliance |
|---|---|---|---|
| T.C.A. Requirement | 90% | 99.5% | |
| January 2019 | 100% | 100.0% | **Yes** |
| February 2019 | 99% | 100.0% | **Yes** |
| March 2019 | 100% | 100.0% | **Yes** |
| April 2019 | 99% | 99.6% | **Yes** |
| May 2019 | 95% | 99.9% | **Yes** |
| June 2019 | 99% | 100.0% | **Yes** |
| July 2019 | 94% | 99.5% | **Yes** |
| August 2019 | 96% | 99.7% | **Yes** |
| September 2019 | 91% | 99.2% | **No** |
| October 2019 | 83% | 93.6% | **No** |
| November 2019 | 100% | 99.9% | **Yes** |
| December 2019 | 100% | 99.9% | **Yes** |

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 September and October 2019.

For September 2019, UPRV proactively informed TDCI of the ECF CHOICES failure and indicated a corrective action had been put in place. The corrective action indicated a system issue caused the processing of claims for one provider to be delayed. Additional controls were put in place to prevent the system issue from recurring.

For October 2019, UPRV proactively informed TDCI of their ECF CHOICES failure and indicated that 377 claims were inappropriately delayed from release during an internal review. Additional monitoring was implemented to prevent future errors from recurring.

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

Management Comments

Management concurs and remediation is complete.

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 (NF) services provided to CHOICES members and thirty (30) claims associated with home and community-based care services (HCBS) provided to CHOICES members. The testing attributes to be utilized by UPRV are defined in the CRA between UPRV and the Division of TennCare. Additionally, subcontractors responsible for processing claims shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor.

UPRV failed to achieve the contractual requirement of 97% claims payment accuracy during September 2019 for nursing facility claims in the East Tennessee Region which reported 96%.

UPRV submitted a corrective action plan which indicated that the failure was due to a system error regarding incorrect loading of provider demographics and has been corrected. During 2019 the Division of TennCare assessed UPRV $5,000 in liquated damages related to claims payment accuracy failures for nursing facility claims.

Management Comments

Management concurs and remediation is complete.

2. Claims Payment Accuracy Reported for NEMT

ATTACHMENT XI Section A.15.5 of the CRA requires UPRV to pay 97% of Non-Emergency Medical Transportation (NEMT) claims accurately upon initial submission. Additionally, ATTACHMENT XI Section A.15.6 of the CRA requires an audit of NEMT claims that complies with the requirements in the CRA regarding a claims payment accuracy audit. The NEMT subcontractor, Tennessee Carriers Inc., performed the audit and reported compliance with monthly claims payment accuracy requirements for all months in calendar year 2019.

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, Inc., to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy reports. The review included verification that the number of claims selected by UPRV, the NEMT subcontractor and the vision subcontractor agreed to requirements of Section A.2.22.6 and ATTACHMENT XI Sections A.15.5 and A.15.6 of the CRA. These interviews were followed by a review of the supporting documentation used to prepare the claims payment accuracy reports.

From UPRV's December 2019 claims payment accuracy reports, TDCI selected for verification all 8 medical claims reported as errors and judgmentally selected 20 claims reported as accurately processed (10 medical, 5 vision, and 5 NEMT). 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. For one attribute, UPRV is required to determine if the allowed amount agrees with the contracted rate

and the terms of the provider agreement. An alternate method was required to test this attribute if the contract in effect was executed by the former owners of the HMO, John Deere Health Plan. For these contracts, the payment exhibit did not specify reimbursement amounts at the procedure code level. To satisfy this attribute, UPRV relied upon system payment tables provided by John Deere Health Plan at the time of acquisition and updated by UPRV as necessary.

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

No deficiencies were noted in TDCI's reverification of the eight claims reported as errors or of the twenty claims reported as accurately processed.

D. Focused Claims Testing

CRA Section A.2.22.7 requires UPRV to monthly self-test the accuracy of claims processing based on claims selected by TDCI. Unlike the random sampling utilized in the claims payment accuracy reporting, claims related to known claims processing issues or claims involving complex processing rules are judgmentally selected for the focused claims testing. Any results reported from focused claims testing are not intended to represent the percentage of compliance or non-compliance for the total population of claims processed by UPRV.

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

For monthly focused claims testing by UPRV during calendar year 2019, 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 2019 included the following:

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

1. Results of Focused Claims Testing

Each month, TDCI provided UPRV with the claims selected for testing and specified the attributes for UPRV to self-test to determine if the claims were accurately processed. For the 900 claims tested for the calendar year 2019, UPRV reported at least one attribute error on 149 claims. It should be noted a claim may fail more than one attribute. For the 149 claims, 169 attribute errors

were reported by UPRV. The following table summarizes the focused claims testing errors reported by UPRV for the calendar year 2019:

| Attribute Tested | Errors Reported by UPRV |
|---|---|
| Data Entry is Verified with Hardcopy Claim | 8 |
| Correct provider is Associated to the Claim | 3 |
| Authorization Requirements Properly Considered | 32 |
| Member Eligibility Correctly Considered | 3 |
| Payment Agrees to Provider Contracted Rate | 2 |
| Duplicate Payment Has Not Occurred | 2 |
| Denial Reason Communicated to Provider Appropriate | 91 |
| Modifier Codes Correctly Considered | 13 |
| Other Insurance Properly Considered | 6 |
| Patient Liability Correctly Applied | 1 |
| Coding-Bundling/Unbundling Properly Considered | 1 |
| Application of Benefit Limits Considered | 7 |
| Total | 169 |

For the 149 claims that contained attribute errors, UPRV identified 62 that were the result of system errors and 87 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 and remediation is complete.

2. Deficiencies Noted by TDCI During Focused Claims

TDCI noted additional claims processing deficiencies in addition to the errors identified by UPRV during monthly focused testing. For each deficiency, TDCI requested UPRV provide additional explanation including the resolution of system configuration issues and the reprocessing of the error claim and all other affected claims. The following represent the additional items noted by TDCI during monthly focused testing for calendar year 2019:

a. Authorization Issues

1. 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. UPRV noted an additional 32 claims with total billed charges of $6,029.28 were also impacted by this error. UPRV indicated all impacted claims have been reprocessed.

2. 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. UPRV noted an additional 105 claims with total billed charges of $9,381.35 were also impacted by this error. UPRV indicated all impacted claims have been reprocessed.

3. 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. UPRV noted an additional 126 claims with total billed charges of $4,534.92 were also impacted by this error. UPRV indicated that all impacted claims have been reprocessed.

Management Comments

Management concurs and remediation is complete.

b. Provider Record Issues

1. 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. UPRV noted an additional 1,428 claims with total billed charges of $2,923,864 were impacted by this error. UPRV indicated that all impacted claims have been reprocessed.

2. 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. UPRV noted an additional 448 claims with total billed charges of $1,749,291.18 impacted by this error. UPRV indicated that all impacted claims have been reprocessed.

Management Comments

Management concurs and remediation is complete.

c. System Coding Issues

1. 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. UPRV noted an additional 1,975 claims with billed charges of $235,782.98 impacted by this error. UPRV indicated that the claims processing system has been corrected and all impacted claims have been reprocessed.

2. 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. A total of 2,874 claims with total billed charges of $1,032,964 were impacted by this error. UPRV indicated that all claims have been reprocessed.

Management Comments

Management concurs and remediation is complete.

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 30 claims for testing in which UPRV reported errors.

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

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, 2019. From the listing, five enrollees were judgmentally selected, and all of the claims processed for those enrollees in calendar year 2019 were analyzed to determine if UPRV had correctly applied copayment requirements of the CRA based upon the enrollees' eligibility status. No deficiencies were noted by TDCI during the copayment testing.

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 45 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, 2020, 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 1,439 claims exceeding 60 days in process. UPRV, including subcontractors, processed 578,651 initial submission claims for the month of July 2020. 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 2019 provider complaint logs to verify the timeliness of provider reconsideration requests. TDCI judgmentally selected 15 provider reconsideration requests for testing, including one for March Vision. 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 all 15 provider reconsideration requests selected, UPRV was in compliance with 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. 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, 2019, TDCI received and processed 150 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 | 65 |
| Previous denial or payment upheld | 58 |
| Previous denial or underpayment partially reversed in favor of the provider | 9 |
| Paid by UPRV upon receipt of complaint | 4 |
| Other inquiries | 5 |
| Ineligible | 6 |
| Resolved | 1 |
| Withdrawn | 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. For the 20 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, 2019, 32 independent reviews were initiated by providers against UPRV. The following is a summary of the reviewer decisions:

| | |
|---|---|
| Reviewer decision in favor of UPRV | 12 |
| Reviewer decision in favor of the provider | 5 |
| Reviewer decision partially for the provider and UPRV | 5 |
| Settled for the provider | 7 |
| Paid by UPRV upon receipt of independent review | 1 |
| 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 April 20, 2020.

E. Provider Agreements

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

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

TDCI requested the executed provider agreements for the 45 claims tested above in Section VI.D.3. The provider agreements selected included one from the NEMT subcontractor and five from the vision subcontractor. Of the 45 claims tested, five claims were submitted by noncontracted providers. The following deficiency was noted in the provider agreements selected for testing:

Thirty-five of the 40 provider agreements selected for testing failed to comply with Section A.2.12.9.48 of the CRA. The provider agreement regulatory appendix was updated through modifications to the provider manual; however, there was no evidence that the providers were given notice of the regulatory amendment through the provider manual update or that the providers were given 30 calendar days to give notice of rejection.

Management Comments

Management concurs and remediation is in process. URPV has implemented trackable distribution to all providers regarding Regulatory Appendix updates, including a 30 day dispute provision. Our delivery methods include:

- Email with read receipt confirmation.
- Fax distribution with fax receipt confirmation
- Certified Mailing with receipt confirmation

F. Provider Payments

Capitation payments to providers were tested during 2019 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 2019 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.

Six subcontract agreements were tested to determine the following: (1) the contract templates were prior approved by TDCI and the Division of TennCare and (2) the executed agreements were on approved templates.

- One of the 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 and related party, 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.

Management Comments

Management concurs and the documents have been submitted to TDCI for approval.

H. Subcontractor Monitoring

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

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

I. Non-discrimination

Section A.2.28.2 of the CRA requires UPRV to demonstrate compliance with Federal and State regulations of Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age of Discrimination Act of 1975, and the Omnibus Budget Reconciliation Act of 1981. Based on discussions with various UPRV staff and a review of policies and related supporting documentation, UPRV was in compliance with the reporting requirements of Section A.2.28.2 of the CRA.

J. Internal Audit Function

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

The Internal Audit Department of UPRV's parent company, UnitedHealth Group, performs internal audits specific to the TennCare plan. The results of the specific reviews by the Internal Audit Department were considered by TDCI during the current examination. The report included findings and responses through Agreed-Upon Action Plans by UPRV's management.

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

K. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., Title 56, Chapter 11, Part 1 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-105 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner…." UPRV is

domiciled in the State of Illinois. TDCI interprets the Act as applying to foreign health maintenance organizations in a manner that treats such foreign entities as a domestic insurer for the purposes of being regulated under the Act. Through a Memorandum of Understanding executed January 14, 2013, UPRV agreed to TDCI's interpretation and consented to be regulated as a domestic insurer under the Act. The review of the annual filing for Illinois is required to also be submitted to TDCI. No discrepancies were noted in the annual holding company registration filing received in 2020 for the calendar year 2019.

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 February 2019 through November 2019. 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 February 2019 through November 2019.

**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, 2017:

A. Financial Deficiencies

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

B. Claims Processing Deficiencies

1. For one month in East Tennessee Region, UPRV failed to achieve claims payment accuracy requirements of 97% per Section A.2.22.6 of the CRA for medical claims.

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

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

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

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

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

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

5. The CRA requires UPRV to self-test the accuracy of claims processing based on claims selected by TDCI on a monthly basis. For the 900 claims tested for calendar year 2017, UPRV reported at least one attribute error on 184 claims during focused claims testing.

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

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

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

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

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

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

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

   - During the review of the procedures utilized by UPRV when testing the attribute "Payment agrees to provider contracted rate", it was noted that UPRV does not verify the claim pricing accuracy with payment terms in the

executed provider contract. UPRV cannot accurately test this attribute without comparing the payment to the contracted fee schedule.

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

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

9. For five enrollees, all of the claims processed for those enrollees in calendar year 2019 were analyzed to determine if UPRV had correctly applied copayment requirements of the CRA based upon the enrollees' eligibility status. During the review, TDCI noted that UPRV incorrectly applied the copayment for two enrollees. The copayment amount for Community Mental Health services should have been $15, but UPRV applied a $5 copayment.

Findings B.2, B.5 and B.6 have been repeated in the current examination.

C. Compliance Deficiencies

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

2. TDCI requested the executed provider agreements for the 45 claims tested above in Section VI.D.3. TDCI noted that 35 of the 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.

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

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

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

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

Findings C.2 and C.3 have been repeated in the current examination.