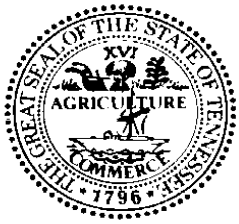


STATE OF TENNESSEE

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

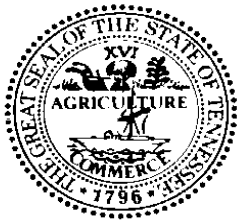
THE TENNCARE OPERATIONS

OF

VOLUNTEER STATE HEALTH PLAN, INC.
d\b\a BlueCare and
d\b\a TennCare Select

CHATTANOOGA, TENNESSEE

FOR THE PERIOD JANUARY 1, 2008
THROUGH DECEMBER 31, 2008



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DATE: February 23, 2011

The examination fieldwork for a Market Conduct Examination and Financial and Compliance Examination of the TennCare Operations only of Volunteer State Health Plan, Inc., Chattanooga, Tennessee was completed July 17, 2009. The report of this examination is herein respectfully submitted.

I. FOREWORD

On May 12, 2009, the TennCare Oversight Division of the Tennessee Department of Commerce and Insurance (TDCI) notified representatives of the TennCare operations of the Volunteer State Health Plan, Inc., (VSHP) of its intention to perform a market conduct, limited scope financial statement, and compliance examination. Fieldwork began on June 22, 2009 and ended on July17, 2009.

This report includes the results of the market conduct examination "by test" of the claims processing system for VSHP's TennCare operations. Further, this report reflects the results of an examination of financial statement account balances as reported for TennCare operations by VSHP. This report also reflects the results of a compliance examination for its TennCare operations of VSHP's policies and procedures regarding statutory and contractual requirements. 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 the TennCare operations of VSHP was conducted jointly by TDCI and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 3-6. of the Contractor Risk Agreement (CRA) for the East Tennessee Grand Region, Section 2.25 of the CRA for West Tennessee Grand Region, and Section 2-15 of the Agreement for the Administration of TennCare Select (AATS) between the State of Tennessee and VSHP, Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) § 56-32-115 and § 56-32-132.

VSHP 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 market conduct examination focused on the claims processing functions and performance of VSHP. 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 financial examination focused on selected balance sheet accounts and the TennCare income statement as reported by VSHP on its National Association of Insurance Commissioners (NAIC) Annual Statement for the Year Ended December

31, 2008, and the Medical Services Monitoring Reports and Medical Loss Ratio Reports filed by VSHP as of December 31, 2008.

The compliance examination focused on VSHP's TennCare provider appeals procedures, provider agreements and subcontracts, and the demonstration of compliance with non-discrimination reporting requirements.

Fieldwork was performed using records provided by VSHP before, during and after the onsite examination from June 22, 2009 through July 17, 2009.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that VSHP's TennCare operations were administered in accordance with the CRA, AATS and state statutes and regulations concerning HMO operations, thus reasonably assuring that VSHP's TennCare enrollees received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

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

III. PROFILE

A. Administrative Organization

VSHP is a wholly owned subsidiary of Southern Diversified Business Services, Inc. (SDBS) which is a wholly owned subsidiary of Blue Cross Blue Shield of Tennessee, Inc. (BCBST). BCBST performs certain administrative functions of VSHP under an administrative services agreement between VSHP and BCBST.

The officers and board of directors for VSHP at December 31, 2008, were as follows:

Officers for VSHP

Vicky Brown Gregg, Chairman
Sonya Kay Nelson, President and CEO
Steven Lee Coulter MD, Managing Director
Robert Stanley DeMerritt, Chief Financial Officer
Albert Irving Koehler, Chief Operating Officer
Daniel Paul Timblin, Treasurer
Alaine Marie Zachary, Assistant Treasurer
Sheila Dean Clemons, Secretary
Katherine Anne Laurance, Assistant Secretary

Board or Directors or Trustees for VSHP

Vicky Brown Gregg
Steven Lee Coulter, MD
John Francis Giblin

B. Brief Overview

Effective November 4, 1996, TDCI granted VSHP (formerly Volunteer State Health Plan II, Inc.) a certificate of authority to operate as a TennCare HMO. VSHP operated this line of business under the plan name BlueCare.

Effective July 1, 2001, VSHP's contract with the TennCare Bureau limited BlueCare enrollment to the East Grand Region. Also effective July 1, 2001, VSHP entered into an agreement with the TennCare Bureau to administer a safety net plan called TennCare Select. Under this agreement, the state, and not VSHP, is at risk for the cost of medical services. TennCare Select provides services for children in state custody or at risk of being placed in state custody, children eligible to receive Social Security Income, children receiving services in an institution or under the State's Home and Community Based Service waiver, and TennCare enrollees residing out of state. Furthermore, TennCare Select in previous years has received additional enrollment from MCOs with terminated TennCare contracts.

Effective July 1, 2002, the CRA with VSHP was amended for BlueCare to temporarily operate under a no-risk agreement. This period, otherwise known as the "stabilization period," was established to allow all MCOs a satisfactory period of time to establish financial stability, maintain continuity of a managed care environment for enrollees and assist the TennCare Bureau in restructuring the program design to

better serve Tennesseans adequately and responsibly. BlueCare agreed to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures as they existed April 16, 2002, unless such a change received approval in advance by the TennCare Bureau.

During stabilization, VSHP received from the TennCare Bureau a monthly fixed administrative payment based upon the number of TennCare enrollees assigned to BlueCare. The TennCare Bureau reimbursed VSHP for the cost of providing covered services to TennCare enrollees. The CRA for the stabilization period expired December 31, 2008.

For the West Tennessee Grand Region effective November 1, 2008 and the East Grand Region effective on January 1, 2009, VSHP is contracted through an at-risk agreement with the TennCare Bureau to receive a monthly capitation payment based on the number of enrollees assigned to VSHP and each enrollee's eligibility classification.

As of December 31, 2008, TennCare Select had approximately 88,000 TennCare members for all Grand Regions and BlueCare had approximately 210,000 TennCare members for the East Tennessee Grand Region and approximately 189,000 for the West Tennessee Grand Region.

C. Claims Processing Not Performed by VSHP

TennCare has contracted with other organizations for the administration and claims processing of these types of services:

- Dental
- Pharmacy

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

- Behavioral Health - ValueOptions of Tennessee, Inc.
- Non-emergency Medical Transportation (NEMT) – Southeastrans, Inc. (SET)

IV. PREVIOUS EXAMINATION FINDINGS

The previous examination findings are provided for informational purposes. The following were claims processing and compliance deficiencies cited in the examination by TDCI for the period January 1, 2006 through June 30, 2006:

A. Financial Deficiencies

1. VSHP overstated its investment income receivable and investment revenue by $20,687. Because VSHP transfers its investment income to the parent, administrative expense and the payable to the parent were similarly overstated.
2. Administrative Expenses as reported on the Underwriting and Investment Schedule – Part 3, were not allocated in accordance with Statutory Accounting Principle Number 70.
3. VSHP incorrectly included $543,734.86 due to the State for premium taxes in General Expenses Due and Accrued.
4. In preparing the Medical Fund Target Report and the Medical Services Monitoring Report, VSHP did not report recoveries of claims payments correctly. These recoveries should be reported as reductions to medical expense in the month the claim was paid rather than in the month claims payments were recovered.

None of the findings are repeated in the current report.

B. Claims Processing Deficiencies

1. VSHP did not maintain a listing of the attributes required to be tested for the claims selected for inclusion in the Claims Payment Accuracy Report.

The finding was not repeated in the current report.

C. Compliance Deficiencies

1. VSHP did not maintain evidence that providers received notification of amendments to their service contracts per section 2.18.cc of the CRA.
2. VSHP did not obtain prior approval from the TennCare Bureau or TDCI before executing an agreement with Vanderbilt University Medical Center for provider credentialing services in violation of Sections 2-9.c and 2-17 of the CRA and Tenn. Code Ann. ¶ 56-32-203(c)(1).
3. At June 30, 2006, VSHP's restricted deposit was deficient by $2,200,000.

Findings similar to item numbered 1 and 2 above are repeated as part of this report.

V. 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 VI, VII, and VIII of this examination report.

A. Financial Deficiencies

1. The Notes to the Financial Statements and the Management Discussion and Analysis to Annual Statement failed to disclosure certain transactions between affiliates related to three administrative service agreements. Additionally, these

agreements were not submitted to TDCI for prior approval pursuant to Tennessee Code Annotated §§56-11-106 and 56-32-103(c)(1).
(See Section VI.A.4.)

2. The medical services monitoring (MSM) report for December 2008 inappropriately included $750,596.61 in Bad Debt expenses in Other Payments /Adjustments to Medical cost. Bad Debt expenses should not be included on the MSM report. Only expenses that relate to medical cost should be reported on the MSM report. Bad debt is considered an administrative expense.
(See Section VI.D.)

B. Claims Processing Deficiencies

1. VSHP did not process claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for the period of June 2008 through January 2009. The plan consistently maintained prompt pay compliance beginning February 2009. TDCI assessed against VSHP an administrative penalty pursuant to the authority of T.C.A. § 56-32-120 in the amount of $60,000.
(See Section VII.A.)

2. VSHP subcontractor, SET failed the contractually required claims payment accuracy standard of 97% for NEMT claims for all of VSHP's TennCare contracts for the fourth quarter 2008.
(See Section VII.C.)

3. The claims payment accuracy audits for NEMT claims is performed by SET's Quality Manager and not by VSHP's Internal Audit department. Section A.15.6 of the NEMT Requirements Attachments to the CRA and AATS states, "The CONTRACTOR shall conduct an audit of NEMT claims that complies with the requirements in the Agreement regarding a claims payment accuracy audit."
(See Section VII.C.2.)

4. For preparation of claims payment accuracy reports, VSHP did not maintain for audit and verification purposes the results of testing for a contractually required testing attribute.
(See Section VII.C.2.)

5. For one of the 100 VSHP claims selected for testing, the comparison of the actual claim with system claim data revealed a procedure code modifier submitted on a provider claim was not entered into VSHP's claims processing system. The omission incorrectly resulted in no payment for the procedure code.
(See Section VII.E.)

6. For two of the ten SET claims selected for testing, the comparison of actual claim with system claim data revealed SET failed to capture all of the contractually required data elements from claims submitted on HCFA claims forms.

(See Section VII.E.)

7. For the 100 claims selected for testing, the following discrepancies related to adjudication accuracy were noted:

   - For one claim, a service line on a claim was incorrectly denied as Medicare as primary resulting in an underpayment of $25.81.

   - As previously noted for one claim, a procedure code modifier submitted on a provider claim was not entered into VSHP's claims processing system. The omission incorrectly resulted in no payment for the procedure code.

   - For one claim, the claim was incorrectly denied with the explanation exceeds timely filing. The claim should have denied with the explanation duplicate submission.

   (See Section VII.F.)

8. For the 100 claims selected for testing processed by VSHP, the following pricing accuracy discrepancies were noted:

   - For two claims, the amount paid did not agree to the contractually negotiated rate in the provider agreement resulting in an underpayment of both claims.

   - For one claim, the amount paid could not be traced to agreement with the provider since no rate was established in the agreement for revenue code 0451.

   (See Section VII.G.)

9. Testing of copayments determined that 14 claims related to visits to community mental health centers were incorrectly applied. The TennCare Bureau had previously informed VSHP of this issue. VSHP was in the processing of correcting errors of this type based on communications with the TennCare Bureau.
   (See Section VII.H.)

10. The application of a copayment to one claim was incorrectly applied for two service lines on a claim.
    (See Section VII.H.)

C. <u>Compliance Deficiencies</u>

1. VSHP did not maintain in the following instances documentation of the receipt of notification of amendments to provider agreements through the provider newsletter:

   - VSHP's documentation for 2nd Quarter updates to the Provider Administration Manual indicated that a notice was left for one provider but no confirmation of

delivery was received.

- VSHP's documentation for 3rd and 4th quarter's updates to the Provider Administration Manual indicated that a notice was left for one provider but no confirmation of delivery was received.

(See Section VIII.B.)

2. From an initial sample of 33 provider contracts selected for testing, VSHP could not provide executed contracts for two behavioral health providers, Cherokee Health Systems and Southeast Mental Health Center, and one transportation provider, UT Lifestar, LLC. Behavioral health providers are contracted through the VSHP subcontractor, Value Options. The accuracy of the provider file submitted to TennCare is critical in determining VSHP's ability to provide the necessary services to TennCare enrollees. VSHP should verify the accuracy of the provider file and establish controls that will not allow a provider to be listed as contracted when an executed contract with VSHP or Value Options does not exist.
(See Section VIII.C.)

3. For two behavioral health provider agreements selected for testing, amendments to the provider agreements were not submitted to TDCI for prior approval in violation of Tenn. Code Ann. § 56-32-103(c)(1) and contractual requirements of Section 2.12.2 of the CRA for the West Tennessee Grand Region.
(See Section VIII.C.)

4. VSHP did not mail the 2009 BlueCare Compliance Amendment to all providers. After documentation for mailing the 2009 BlueCare Compliance Amendment was requested by TDCI, VSHP discovered that the Amendment was not sent to all providers. Ancillary providers were omitted from the mailing. On June 26, 2009, VSHP mailed the Amendment to ancillary providers with an effective date of August 1, 2009.
(See Section VIII.C.)

5. During the test of subcontracts, it was determined that the administrative service agreements between VSHP and BCBST for the management services related to Cover Tennessee Program, MedAvantage, and other medical management services were not submitted for prior approval to TDCI as a material modifications to VSHP's Certificate of Authority.
(See Section VIII.E.)

6. A subcontract to Trizetto for claims processing services was not submitted to TDCI for prior approval as a material modification to VSHP's Certificate of Authority. Trizetto is an affiliate of BCBST. The claims processing software, FACETS, is a product of Trizetto.
(See Section VIII.E.)

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, VSHP is required to file annual and quarterly NAIC 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 VSHP 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.

VSHP reported total net loss of $ 61,776,488 on the statement of revenue and expenses. On December 4, 2009, the BCBST Board of Directors approved a transfer in aggregate amount of $50,000,000 to VSHP and on December 5, 2008, an additional amount not to exceed $80,000,000 was approved. As of November 2009, $72,000,000 had been transferred.

1. Capital and Surplus

Tenn. Code Ann. § 56-32-112(a)(2) requires VSHP 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 licensed in Tennessee are to be included in the calculation of net worth and deposit requirements, regardless of the reporting requirements for the NAIC statements.

Effective November 1, 2008, VSHP executed an additional contract with the TennCare Bureau for expansion into the West Tennessee Grand Region. Section 2.21.5.2.2 of the West CRA Agreement requires that the calculation of minimum net worth shall be based upon annual projected premiums including the estimated premiums for the additional enrollment versus the prior year actual premium revenue. Estimated premiums will be based on the capitation payment rates in effect at the time of the calculation and projected future enrollment.

2008 Statutory Net Worth Calculation

At December 31, 2008, VSHP reported $151,642,822 in admitted assets, $203,080,010 in liabilities and $26,856,301 in capital and surplus on the Annual Statement for the Year Ended December 31, 2008 submitted April 23, 2009. VSHP received approval from TDCI on October 31, 2008, for a significant enrollment expansion into the West Tennessee Grand Region pursuant to TCA §56-32-103(c)(2). Per CRA Section 2.21.5.2., a significant enrollment expansion requires the recalculation of minimum net worth requirements based upon annual projected premiums including the estimated premiums for the additional enrollment. On October 18, 2008, VSHP agreed to a recalculated minimum net worth requirement of $25,326,692 based on projected premiums totaling $1,438,446,121 for calendar year 2009. VSHP's reported net worth at December 31, 2008 was $1,529,609 in excess of the minimum required.

During 2009, the company communicated several initiatives to reduce medical costs including rate reductions in provider payments. Additionally the parent company, BCBST, has infused capital of $72,000,000 including $40,000,000 that was accrued as of December 31, 2008. An additional $60,000,000 capital contribution from the Parent was accrued as of December 31, 2009, including $58,000,000 that was received in February 2010.

VSHP's cost control measures and the capital infusions have improved VSHP's excess net worth status. Review of the Annual Statement for the year ended December 31, 2009, notes VSHP reported capital and surplus of $86,912,408. The required minimum net worth for December 2009, was increased to $28,764,984. VSHP reported net worth at December 31, 2009, was $58,147,424 in excess of the minimum required.

TennCare Premium Revenue for the Examination Period

For the examination period January 1 through December 31, 2008, the following is a summary of VSHP's premium revenue from TennCare operations as defined by Tenn. Code Ann. § 56-32-112(a)(2):

East Tennessee Grand Region

Administrative fee payments from TennCare for the period January 1 through December 31, 2008	$31,437,785
Reimbursement for medical payments from TennCare for the period January 1 through December 31, 2008	459,467,241
Reimbursement for premium tax payments from TennCare for the	9,800,905

period January 1 through December 31, 2008		
Total East Tennessee premiums for the period January 1 through December 31, 2008		$500,705,931
West Tennessee Grand Region		
Total West Tennessee premiums for the period November 1 through December 31, 2008		$72,073,531
TennCare Select		
Administrative fee payments from TennCare for the period January 1 through December 31, 2008	$30,280,473	
Reimbursement for medical payments from TennCare for the period January 1 through December 31, 2008	327,504,583	
Reimbursement for premium tax payments from TennCare for the period January 1 through December 31, 2008	7,936,434	$365,721,490
Total TennCare Premiums		
Total premiums for TennCare operations for the period January 1 through December 31, 2008		$938,500,952

2. Restricted Deposit

Beginning July 1, 2005, an amendment to the non-risk CRA for the East Tennessee Grand Region and TennCare Select required MCOs to have on deposit an amount equal to the calculated statutory minimum net worth requirement. The risk contract for the West Tennessee Grand Region effective November 1, 2008, has similar provisions. In addition Section 2.21.5.4 for the West Tennessee Grand Region states:

> TDCI shall calculate the amount of the increased restricted deposits based on the CONTRACTOR's TennCare premium revenue only unless this calculation would result in restricted deposits below the statutory

requirements set forth in TCA 56-32-212 related to restricted deposits; in which case the required amount would be equal to the statutory requirement as it is calculated by TDCI.

Utilizing only TennCare premiums, the calculation does not result in a restricted deposit below the statutory requirements set forth in Tenn. Code Ann. § 56-32-112. Effective November 1, 2008, CRA Section 2.21.5.4 for West Tennessee Grand Region, required an increase in restricted deposit equal to the increase in minimum net worth as a result of the significant enrollment expansion.

The total TennCare premiums utilized in the deposit calculation included $459,588,637 for estimated 2009 premiums for the West Tennessee Grand Region and $617,382,395 for estimated 2009 premiums in East Tennessee Grand Region, and $361,475,089 in 2008 actual premiums for TennCare Select.

Based upon estimated TennCare premium revenues of $1,438,446,121, VSHP's statutory deposit requirement at November 1, 2008, was $25,326,692. On October 23, 2008, VSHP complied with the contractual requirement by amending the depository agreement and providing additional safekeeping receipts for a total of $25,400,000 restricted deposit.

3. Claims Payable

As of December 31, 2008, VSHP reported $62,220,304 claims unpaid, $8,798,831 unpaid claims adjustment expense, and $42,663,267 aggregate health policy reserves on the Annual Statement for the Year Ended December 31, 2008. Theses amounts were certified by a separate statement of actuarial opinion.

The claims unpaid amount represents an estimate for the West Tennessee Grand Region at-risk operations for TennCare for the period November 1, 2008 through December 31, 2008. Based on a review of the payments after December 31, 2008, the liability was sufficient to meet the actual unpaid claims.

The unpaid claims adjustment expense represents a liability of administrative costs to processing claims that have been incurred but not received or processed as of December 31, 2008.

The aggregate health policy reserves represent the premium deficiency VSHP would incur as a result of risk contracts with the TennCare Bureau. Subsequently with the submission of the NAIC Quarterly Statement as of March 31, 2009, this liability was reduced to $20,016,490 and then eliminated by submission NAIC Quarterly Statement as of June 30, 2009. VSHP reconsidered estimated premiums compared to costs associated with the risk contracts over the term of the contract and determined the recognition of the premium deficiency was not required. The subsequent reduction and elimination of this

liability would have a positive effect on net income and net worth if reconsidered as of December 31, 2009, however no examination adjustment was considered necessary because of the conservative nature of the liability.

4. Management Agreement and Administrative Expense Allocations

Some administrative expenses such as salaries are incurred directly by VSHP, while other administrative expenses are paid to the parent, BCBST. The fee paid to BCBST for administrative services is based on a management agreement previously approved by TDCI. The fees paid to BCBST 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.

The allocation methodology utilized by BCBST was reviewed. BCBST's methodology entitled, "Hybrid Cost Allocation", recognizes allocated costs and costs based on resource consumption. Allocated costs are determined utilizing drivers such as claims counts and number of members. Resource consumption methodology determines for various cost centers VSHP's related costs by applying ratios such as headcounts of employees, percent of salaries or calculated standard rates. Testing by TDCI included interview of appropriate personnel, analytical testing of salary ratios and recalculation of drivers within the cost centers. Additionally four cost centers were selected to verify a sample of source documents. Review of the allocation methodology did not reveal any discrepancies with the principles of SSAP 70.

The Notes to the Financial Statements and the Management Discussion and Analysis to Annual Statement require the disclosure of transactions between affiliates. The following discrepancies were noted during testing and reconciliation of allocated costs paid to BCBST compared to the reported affiliate disclosures on the Annual Statement for the year ended December 31, 2008:

- BCBST contracts with the State of Tennessee Cover Tennessee programs. BCBST subcontracts through an administrative service agreement with VSHP to provide claims processing, customer service, contract administration, medical management, and membership services for the Cover Tennessee programs.

- BCBST has a separate administrative service agreement with VSHP to provide medical director review of appeals and denials for BCBST's MedAdvantage program.

- BCBST has a separate administrative service agreement with VSHP to provide medical management and related services.

A discussion of these transactions was not disclosed in the Annual Statement for the year ended December 31, 2008. None of the administrative services agreements were submitted to TDCI for prior approval pursuant to Tennessee Code Annotated §§56-11-106 and 56-32-103(b). Subsequently, on September 28, 2009, TDCI received from VSHP the administrative service agreement between VSHP and BCBST for Cover Tennessee programs. An acceptance letter regarding the administrative agreement for the Cover Tennessee Program was sent by TDCI on October 20, 2009. On February 16, 2010, TDCI received an amended Annual Statement for the year ended December 31, 2008 which correctly disclosed the omitted affiliate transactions. On May 28, 2010, TDCI received from VSHP additional amendments to administrative service agreements to correct the remaining deficiencies. The amendments were approved by TDCI on June 7, 2010.

Management Comments

Management concurs. We have had numerous communications with TDCI to resolve this issue, resulting in submission and approval of Administrative Services Agreements (ASAs) documenting all services between VSHP and its parent company, BCBST. The Cover Tennessee ASAs (3 total) were filed initially with TDCI on September 28, 2009, and approved by TDCI on October 20, 2009. The medical management ASA was initially filed with TDCI on March 12, 2010, but was disapproved. VSHP has subsequently worked with TDCI to update and consolidate all existing ASAs in order to streamline and consolidate these agreements. These revised ASAs were filed with TDCI on June 3, 2010 and approved June 7, 2010.

As of August 18, 2010, all revised and new ASAs have been executed by the respective officers of VSHP and BCBST with effective dates retroactive to January 1, 2008, the date that these services were first rendered and compensation exchanged between the parties.

B. TennCare Operating Statements

1. TennCare Operating Statement for Non-Risk Operations of the East Tennessee Grand Region and the TennCare Select Program

The CRA for the East Tennessee Grand Region and AATS for TennCare Select between VSHP and the State of Tennessee does not currently hold VSHP

financially responsible for medical claims. This type of arrangement is considered "administrative services only" (ASO) by the NAIC. Under the NAIC guidelines for ASO lines of business, the financial statements for an ASO exclude all income and expenses related to claims, losses, premiums, and other amounts received or paid on behalf of the uninsured ASO. In addition, administrative fees and revenue are deducted from general administrative expenses. Further, the ASO lines of business have no liability for future claim payments; thus, no provisions for Incurred But Not Reported (IBNR) are reflected on the balance sheet.

Although VSHP is under an ASO arrangement as defined by NAIC guidelines, the CRA for the East Tennessee Grand Region and the AATS for TennCare Select require a deviation from ASO reporting guidelines. The required submission of the TennCare Operating Statement should include quarterly and year-to-date revenues earned and expenses incurred as a result of the contractor's participation in the State of Tennessee's TennCare program as if TennCare operations for VSHP in the East Tennessee Grand Region were still operating at-risk. As stated in Section 2-10.h.2. of the CRA for the East Tennessee Grand Region and Section 2-10.h.2 of the AATS for TennCare Select, VSHP is to provide "an income statement detailing the CONTRACTOR's fourth quarter and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the State of Tennessee's TennCare Program." TennCare HMOs provide this information each quarter on the Report 2A submitted as a supplement to the NAIC financial statements. No deficiencies were noted during the review of TennCare Operating Statements for the East Tennessee Grand Region and the TennCare Select program for the year ended December 31, 2008.

2. TennCare Operating Statement of the At-Risk Operations of the West Tennessee Grand Region

Sections 2.30.14.3.3 and 2.30.14.3.4 of the CRA for the West Tennessee Grand Region 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. No deficiencies were noted during the review of TennCare Operating Statement for the West Tennessee Grand Region.

C. Administrative Fee at Risk

Effective July 1, 2005, the CRA was amended to include shared risk incentives for the administrative fee payments received by the plan. Section 3-10.i.3. of the CRA for the East Tennessee Grand Region set ten percent (10%) of the administrative fee at risk; 10% will either be earned or lost based on the plan performance. The CRA defines benchmark periods for the following shared risk incentives from which

performance levels are determined:

Shared Risk Initiative
Medical Services Budget Target
Usage of Generic Drugs
Completion of Major Milestone for National Committee for Quality Assurance (NCQA)
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Compliance
Non-Emergency ER Visits per 1000
Inpatient Admissions per 1000
Inpatient Days per 1000

In addition, Section 3-10.i.4. of the CRA for the East Tennessee Grand Region established an additional bonus pool of fifteen percent (15%) for each Risk Initiative through July 1, 2006. Effective July 1, 2007, the bonus pool will represent twenty percent (20%) of the administrative fee.

VSHP earned $1,095,848.96 for ESPDT for fiscal year 2008 and additional funds from the bonus pool of $1,490,206.77 for fiscal year 2008 for favorable performance related to risk initiatives.

D. Medical Services Monitoring

Effective July 1, 2002, the CRA for the East Tennessee Grand Region requires that VSHP submit a Medical Services Monitoring Report (MSM) on a monthly basis. The MSM reports medical payments and IBNR based upon month of service as compared to a target monthly amount for the enrollees' medical expenses. Although estimates for incurred but not reported claims for ASO plans are not included in the NAIC financial statements, these estimates are required to be included in the MSM. VSHP submitted monthly MSM reports which reported actual and estimated monthly medical claims expenditures to be reimbursed by the TennCare Bureau. The estimated monthly expenditures are supported by a letter from an actuary which indicates that the MSM estimates for IBNR expenses have been reviewed for accuracy.

Based on the review of VSHP's medical services monitoring (MSM) report for December 2008, it was determined that VSHP inappropriately included $750,596.61 in Bad Debt expenses in Other Payments /Adjustments to Medical cost. Bad Debt expenses should not be included on the MSM report. Only expenses that relate to medical cost should be reported on the MSM report. Bad debt is considered an administrative expense.

Management Comments

Management concurs. The Stabilization Plan contract, which termed December 31, 2008, required monthly MSM reporting. VSHP continued to report run-out under the contract through June 30, 2010. Although the Stabilization Plan contract is no longer in effect, VSHP recognizes the need to resolve a similar reporting issue in the Medical Loss Ratio (MLR) reports, which are required by the East and West Risk contracts. Effective with the July 2010 reporting period, VSHP will exclude bad debt expense from the incurred medical claims section of the MLR. The exclusion will result in a reconciling item between the Incurred Medical Expense line on the NAIC Department of Insurance filing and the Incurred Medical Expense line of the MLR.

E. Medical Loss Ratio Report

Section 2.30.14.2.1 of the CRA for the West Tennessee Grand Region requires:

> The CONTRACTOR shall submit a *Medical Loss Ratio Report* monthly with cumulative year to date calculation using the forms in Attachment IX, Exhibit N. 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 September 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 must reconcile to NAIC filings including the supplemental TennCare income statement.

The medical loss ratio (MLR) report as submitted for the period ending December 31, 2008, reported a medical loss ratio of 97.71%. Premium taxes are 2% of total premiums. In order for VSHP to break even the MLR should be 88%. TDCI is concerned with the reported MLR percentage and therefore, monitors monthly the changes to this percentage. Because of the significant excess net worth previously discussed, TDCI has not taken any other regulatory action at this time. A review of the MLR report submitted for December 2008 indicates an increased MLR percentage of 107.88%.

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

F. Umbrella Agreement

In addition to the CRA and AATS agreements, VSHP also contracts with the State of Tennessee through a TennCare Umbrella Participation Agreement. The Umbrella Agreement includes language defining enrollment limits, special payments, and minimum financial guarantees. Section 2.F. states:

> In the event that the total of administrative fee payments paid to the Contractor according to the terms and conditions of the CRA and the terms and conditions of the Select Agreement are less than five million dollars ($5,000,000.00) per month for the period January 1, 2006 through December 31, 2006, TennCare shall make payment equivalent to the difference between the total of administrative fee payments made pursuant to the CRA and administrative fee payments made pursuant to the Select Agreement and five million dollars ($5,000,000.00) per month for the period January 1, 2006 through December 31, 2006, within 120 calendar days of December 31, 2006. Administrative fee payments for retroactive eligibility periods shall be counted in the month to which the payment applies. The TennCare Umbrella Participation Agreement continued through October 31, 2008.

For the examination period, January 1 through October 31, 2008, monthly administrative fee payments exceeded the minimum financial guarantees of the Umbrella Agreement.

G. Subsequent Event

On January 1, 2009, VSHP began administering an at risk TennCare plan for the East Tennessee Grand Region. The initial enrollment for this plan was approximately 242,000 enrollees.

H. Schedule of Examination Adjustments to Capital and Surplus

There were no adjustments to capital and surplus as a result of the examination.

VII. 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 2-18. of the CRA for the East Tennessee Grand Region, Section 2.22.4 of the CRA for the West Tennessee Grand Region and 2-1.i. of the AATS for TennCare Select. 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.

During the beginning of the examination period, TDCI determined compliance with Tenn. Code Ann. § 56-32-126(b)(1) by testing in three-month increments data file submissions of claims processed under each of VSHP's contracts. Each month was tested in its entirety for compliance with the prompt pay requirement of Tenn. Code Ann. If VSHP failed to meet the prompt pay standards in any of the three months tested, TDCI, at a minimum, required claims data submissions on a monthly basis for the next three months to ensure VSHP remained compliant. Beginning with the October 2009 time period, all TennCare MCOs were required to submit data files monthly.

All of the contracts between VSHP and TennCare include an Attachment describing NEMT requirements. Section A.19.5.1 of this Attachment requires the calculation of the prompt pay requirements of Tenn. Code Ann. § 56-32-126(b)(1) for only NEMT claims.

The prompt pay testing results by TDCI for the examination period, as well as through the end of calendar year 2009, are presented for the East Tennessee Grand Region, West Tennessee Grand Region, TennCare Select and total combined in the tables provided below.

The results presented include claims processed by SET for NEMT claims. VSHP has subcontracted with SET to provide NEMT services. SET began providing services in September 2008 with the first claims submitted for payment in October 2008. Separate testing by TDCI of NEMT claims processed by SET determined

SET was in compliance with prompt pay standards of Tenn. Code Ann. § 56-32-126(b)(1) and NEMT Attachment Section A.19.5.1. to the CRAs and AATS.

East Tennessee Grand Region BlueCare Non-Risk	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
2008			
January	95%	99.9%	**Yes**
February	99%	99.6%	**Yes**
March	98%	99.9%	**Yes**
April	98%	99.9%	**Yes**
May	93%	99.9%	**Yes**
June	87%	99.8%	**No**
July	83%	99.6%	**No**
August	88%	99.2%	**No**
September	88%	96.2%	**No**
October	92%	98.4%	**No**
November	94%	98.6%	**No**
December	88%	98.0%	**No**
2009			
January	84%	98.8%	**No**
February	73%	98.6%	**No**
March	88%	99.2%	**No**
April	90%	98.2%	**No**
May	95%	98.8%	**No**
June	86%	95.7%	**No**
July	84%	98.2%	**No**
August	85%	99.7%	**No**
September	83%	98.1%	**No**
October	92%	98.8%	**No**
November	96%	99.2%	**No**
December	96%	99.8%	**No**

TennCare Select	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
2008			
January	94%	99.8%	**Yes**
February	98%	99.6%	**Yes**
March	98%	99.6%	**Yes**
April	98%	99.8%	**Yes**
May	96%	99.6%	**Yes**
June	84%	99.7%	**No**
July	81%	99.3%	**No**
August	88%	99.1%	**No**
September	88%	96.1%	**No**
October	89%	98.5%	**No**
November	90%	98.2%	**No**
December	88%	97.7%	**No**
2009			
January	84%	98.9%	**No**
February	93%	99.5%	**Yes**
March	96%	99.8%	**Yes**
April	97%	99.7%	**Yes**
May	96%	99.6%	**Yes**
June	94%	99.6%	**Yes**
July	94%	99.6%	**Yes**
August	94%	99.6%	**Yes**
September	95%	99.6%	**Yes**
October	96%	99.6%	**Yes**
November	98%	99.8%	**Yes**
December	93%	99.7%	**Yes**

West Tennessee Grand Region (effective November 1, 2008)	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
2008			
November	100%	100.0%	**Yes**
December	97%	100.0%	**Yes**
2009			
January	90%	99.9%	**Yes**
February	92%	100.0%	**Yes**
March	96%	99.9%	**Yes**
April	99%	99.9%	**Yes**
May	97%	99.8%	**Yes**
June	97%	99.9%	**Yes**
July	97%	99.9%	**Yes**
August	97%	99.8%	**Yes**
September	98%	99.8%	**Yes**
October	99%	99.9%	**Yes**
November	98%	99.8%	**Yes**
December	99%	99.7%	**Yes**

VSHP Combined	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
2008			
January	95%	99.9%	**Yes**
February	98%	99.6%	**Yes**
March	98%	99.9%	**Yes**
April	98%	99.9%	**Yes**
May	93%	99.9%	**Yes**
June	86%	99.8%	**No**
July	82%	99.5%	**No**
August	88%	99.2%	**No**
September	89%	96.2%	**No**
October	91%	98.5%	**No**
November	93%	98.6%	**No**
December	90%	98.4%	**No**
2009			
January	88%	99.3%	**No**
February	92%	99.7%	**Yes**
March	96%	99.9%	**Yes**
April	98%	99.9%	**Yes**
May	97%	99.8%	**Yes**
June	96%	99.8%	**Yes**
July	97%	99.9%	**Yes**
August	96%	99.8%	**Yes**
September	97%	99.8%	**Yes**
October	98%	99.8%	**Yes**
November	99%	99.9%	**Yes**
December	98%	99.8%	**Yes**

When combining the results for all claims processed, VSHP was in compliance with Tenn. Code Ann. § 56-32-226(b)(1) for the period of January 2008 through May 2008. However, VSHP did not process all claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for the period of June 2008 through January 2009. VSHP responded monthly with corrective action plans to TDCI's prompt pay results letters. Reasons for the failures included the adoption of the National Provider Identification requirements and the conversion to the Facets claims processing system. The plan consistently maintained prompt pay compliance based upon all claims processed by VSHP beginning February 2009. TDCI assessed against VSHP an administrative penalty pursuant to the authority of T.C.A. § 56-32-120 in the amount of $60,000.

In addition to administrative penalties assessed by TDCI, Section 4.8 of CRA for the East Tennessee Region permits the Bureau of TennCare to assess liquidated damages of $10,000 for each month VSHP is not in compliance with prompt pay standards. It should be noted that claims processed for the east Tennessee Grand Region non-risk contract continued to fail compliance in 2009. This contract ended December 31, 2008, and processing during 2009 represented run-out claims processing.

Management Comments

Management concurs.

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 VSHP's claims processing system.

The following items were reviewed to determine the risk that VSHP 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, and
- Review of internal controls related to claims processing.

No significant deficiencies were noted during the review of the risk associated with claims processing. The initial claims testing sample size was not expanded.

C. Claims Payment Accuracy Reports

Section 2-9.b. of the CRA for the East Tennessee Grand Region, Section 2.22.6 of the CRA for the West Tennessee Grand Region and Section 2.9.12.2. of the AATS for TennCare Select require that 97% of claims are paid accurately upon initial submission. VSHP is required to submit quarterly a claims payment accuracy report 30 days following the end of each quarter.

VSHP for the East Tennessee Grand Region reported the following results for 2008:

East Tennessee – Non-risk	Results Reported	Compliance
First Quarter	100%	**Yes**
Second Quarter	100%	**Yes**
Third Quarter	99%	**Yes**
Fourth Quarter	98%	**Yes**

VSHP for the West Tennessee Grand Region reported the following results for the fourth quarter of 2008:

West Tennessee Risk	Results Reported	Compliance
Fourth Quarter	98%	**Yes**

VSHP for the TennCare Select reported the following results for 2008:

TennCare Select	Results Reported	Compliance
First Quarter	99%	**Yes**
Second Quarter	99%	**Yes**
Third Quarter	99%	**Yes**
Fourth Quarter	98%	**Yes**

During the examination period, VSHP was in compliance with claims payment accuracy requirements of the CRAs for the East and West Tennessee Grand Regions and the AATS for TennCare Select.

The NEMT Attachments Section A.19.5.2. requires that 97% of NEMT claims are paid accurately upon initial submission. VSHP is required to submit quarterly a claims payment accuracy report 30 days following the end of each quarter.

SET, the subcontractor processing NEMT claims, provided the following results of claims payment accuracy testing for the Fourth Quarter 2008 by VSHP's TennCare contracts:

SET – NEMT Claims	Results Reported	Compliance
East Tennessee Region	89%	**No**
West Tennessee Region	89%	**No**
TennCare Select	79%	**No**

SET failed the contractually required claims payment accuracy requirements for NEMT claims for all of VSHP's TennCare contracts for the fourth quarter 2008. The following errors were noted by SET and should have been denied instead of paid by SET:

1. Missing or incorrect times and/or odometer readings
2. Modifier codes did not matching the location
3. Incorrect procedure code
4. Non-eligibility at the date of service of the claim

Management Comments:

Management concurs, but would like to offer the following for clarification purposes:

1) Missing or incorrect times and/or odometer readings. This information is tracked by SoutheasTrans internally as information only and is not used in the calculation of the NEMT provider payment. The trip distance used for payment calculation purposes is determined by Southeastrans' scheduling and dispatch software and presented to the NEMT provider on the trip manifest. NEMT Providers know when they accept the trip manifest what the basis for the mileage payment will be.

   During the first few months of SoutheasTrans implementation in Tennessee, we were lenient on claims missing odometer readings since that information was not critical in determining the claim payment. NEMT Providers who submitted claim forms without odometer readings were contacted by telephone and advised that, although we had approved payment without the odometer readings, we would not continue to do so in the future and that claims without odometer readings would be denied. Effective in the first quarter of 2009, SoutheasTrans began denying claims without the required odometer readings. SoutheasTrans remittance advice contains a denial code stating "Missing odometer reading" when appropriate.

   The only exception is ambulance services who submit claims on CMS 1500 forms. Since there is no data field on the 1500 claim for odometer readings,

SoutheasTrans has not denied payment for ambulance claims submitted on 1500 forms solely due to missing odometer readings.

SoutheasTrans Corrective Action: SoutheasTrans will notify all ambulance providers submitting claims on 1500 forms that odometer readings must be manually entered in the top right corner of the claim forms or alternatively the ambulance providers may submit copies of driver's logs showing odometer readings along with the 1500 claim form. SoutheasTrans will notify all affected ambulance services no later than August 20, 2010 and will begin denying ambulance claims without odometer readings on claim forms for dates of service on or after September 20, 2010.

2) Modifier codes did not match the location. Modifier codes are assigned by SoutheasTrans at the time of the trip reservation. NEMT Providers are given the actual pick-up and drop-off addresses on their manifests, but they do not ever see the modifier codes. Therefore, modifier codes are not presented to SoutheasTrans on claims from NEMT providers, so no claims are denied based on modifier errors.

   SoutheasTrans' IT Department performs edit checks prior to the submission of the encounter data report. These edit checks compare the pick-up and drop-off locations to the assigned modifier codes and if an error is recognized the system either makes a correction to the modifier or prints the claim on an exception report for manual review. This process does not always capture 100% of the errors, so SoutheasTrans' IT staff continually refines the edit check logic to capture more errors. For example, the edit checks are run daily and the number of errors detected are recorded. The logic primarily checks to assure that pick-ups or drop-offs at a member's home have an "R" modifier and that hospitals have an "H" modifier. It also checks for invalid modifier combinations such as RR. Invalid combinations are printed on an exception report for manual review and correction.

   SoutheasTrans' ultimate solution for correcting modifier errors will be addressed in an upcoming software release. In the new software, modifier codes will be assigned to each location type which more closely aligns with the nature of the pick-up and drop-off locations. The modifier code/location type table will be maintained by management staff and call center agents will no longer have to "manually" assign the modifier code during the trip registration process. Instead, the agents will select the appropriate location type, such as physician's office, dialysis center, or hospital, and the correct modifier code for that location type will be automatically associated with each location. We believe this enhancement, which is scheduled to be implemented in August, will dramatically reduce, if not totally eliminate all modifier coding errors. We will continue to run edit checks to identify and correct errors prior to the submission of the encounter data files.

SoutheasTrans Corrective Action: In the event that modifier or other coding errors are not recognized and corrected, SoutheasTrans will correct the errors upon discovery and will resubmit corrected claims on the encounter data reports. This action will require a programming change within our new software which will require time for development and testing. SoutheasTrans will initiate submission of corrected coding errors on encounter data files as soon as possible, but no later than November 1, 2010.

3) Incorrect procedure code. Procedure codes are set up within Southeastrans' trip scheduling and dispatch software based on the mode of transportation authorized. NEMT providers do not submit procedure codes on their claim; therefore SoutheasTrans does not deny claims due to an error that occurred in their system. Any incorrect procedure codes identified have been corrected.

   NEMT Providers submit claim information on SoutheasTrans' Trip Reimbursement Form which includes the following data elements: NEMT Provider name, NEMT Provider Number, Vehicle VIN, SET Decal Number, Driver's Name, Driver's Signature, Attendant's Name (if applicable), TennCare Region, Date of Service, Member Name, Trip Confirmation Number, Special Rate Authorization, Pick-up Time, Pick-up Mileage, Drop-off Time, Drop-off Mileage, Transport Code, Manifest Mileage, Member Signature, Escort Name and Relationship (if applicable), Trip Status Code, and NEMT Provider Comments (if applicable).

   The only exception to the Trip Reimbursement Form involves licensed ambulance services that submit claims on the CMS 1500. SoutheasTrans will initiate software changes to capture and report procedure codes and ICD-9 codes as submitted on CMS 1500 forms by ambulance services. This change will be implemented as soon as possible, but no later than November 1, 2010.

4) Non-eligibility at the date of service of the claim. SoutheasTrans is responsible for determining member eligibility prior to authorizing the trip and assigning it to an NEMT provider. Since member eligibility may change during the interval between the reservation date and the date of service, SoutheasTrans re-checks member eligibility daily for all members with trips scheduled to occur on that day. Occasionally, the daily member import file is not received until after trips have begun to occur and it is possible that we are not aware that a member has become ineligible until after the trip has occurred. If that occurs and the NEMT provider ran the trip as authorized by SoutheasTrans, then SoutheasTrans has an obligation to the NEMT provider to pay the claim as authorized. The risk of this type of error could be reduced if the daily member import file could be made available before 6:00 a.m.

   This issue occurred in the 4th Quarter of 2008. In the 1st Quarter of 2009, VSHP developed an automated process for sending eligibility files to SoutheasTrans. Normally, the eligibility files are uploaded to the VSHP secure server around

5:30 a.m. for transmission to SoutheasTrans. However, at times the eligibility file is so large that the transmission to SoutheasTrans takes longer than 30 minutes. VSHP is currently in the process of evaluating a separate report to submit to SoutheasTrans prior to 6:00 am. The separate report will be smaller and will consequently transmit to SoutheasTrans more quickly in order to meet the 6:00 a.m. timeframe.

1. Procedures to Review the Claims Payment Accuracy Reports

   The review of the claims payment accuracy reports included an interview with VSHP and SET responsible staff 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 VSHP and SET agreed to requirements of Section 2-9.m.2. of the CRA for the East Tennessee Grand Region, Section 2.22.6.4 of the CRA for the West Tennessee Grand and Section 2-9.12.2 of the AATS for TennCare Select, as well as the requirements of the NEMT Attachments Section A.19.5.2. These interviews were followed by a review of the supporting documentation used to prepare the 2008 fourth quarter reports for East, West, TennCare Select and NEMT. All of the claims reported as errors were reviewed for verification by TDCI. Twenty claims from VSHP samples reported as accurately processed by VSHP were also selected for verification by TDCI. 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 VSHP, TDCI tested these claims to the attributes required in Section 2-9.m.2. of the CRA for the East Tennessee Grand Region, Section 2.22.6.4 of the CRA for the West Tennessee Grand Region and section 2-9.12.2 of the AATS for TennCare Select.

2. Results of the Review of the Claims Payment Accuracy Reporting

   a. The claims payment accuracy audits for NEMT claims is performed by SET's Quality Manager and not by VSHP's Internal Audit department. Section A.15.6 of the NEMT Attachments of the CRAs and ATTS state, "The CONTRACTOR shall conduct an audit of NEMT claims that complies with the requirements in the Agreement regarding a claims payment accuracy audit."

      Management Comments

      Management concurs. The BlueCross BlueShield of Tennessee (BCBST) Internal Audit department is working directly with SoutheasTrans to transition the claims payment accuracy audits to their area. The BCBST Internal Audit department will begin auditing claims received no later than December 31, 2010.

b. CRA Section 2.9.m.2 for the East Tennessee Grand Region, Section 2-9.12.2 of the AATS for TennCare Select, and CRA Section 2.22.6.4. for the West Tennessee Grand Region list the minimum testing attributes VSHP must consider when preparing the claims payment accuracy reports. CRA Section 2.22.6.5 for the West Tennessee Grand Region requires VSHP to maintain for audit and verification purposes the results for each attribute tested for each claim selected. The attribute listing provided by VSHP did not include the contractually required "Effect of modifier codes correctly applied".

Management Comments

In 2006, we created an automated checklist to capture each attribute desired by the State. This finding concentrates on specifically listing the "effect of modifiers" in the checklist. We have added this exact wording to the checklist to ensure the wording matches that desired by the State and to eliminate any opportunity for misunderstanding. However, it is important to note that this attribute was already covered in the claims audit process in the determination of the correct allowed amount.

D. Claims Selected For Testing From Prompt Pay Data Files

The claims sample, judgmentally selected from previously submitted for prompt pay data testing, consisted of 25 East Tennessee claims, 25 TennCare Select claims, 50 West Tennessee claims, and 10 NEMT claims processed by SET. The previously submitted December 2008 data files of all processed claims utilized in prompt pay testing represented the population of claims from which claims were selected. The selected claims included high paid dollar claims, adjusted claims, and denied claims. The number of claims selected for testing was not determined statistically. The results of testing are not intended to represent the percentage of compliance or non-compliance for the total population of claims processed by VSHP.

To ensure that the December 2008 data files included all claims processed in the month, the total amount paid per the data files was reconciled to the triangle lags within an acceptable level.

E. Comparison of Actual Claim with System Claim Data

The purpose of this test is to ensure that the information submitted on the claim was entered correctly in VSHP and SET's claims processing systems. The CRA requires minimum data elements to be recorded from medical claims and submitted to TennCare as encounter data. The data elements recorded on the claims selected for testing were compared to the data elements entered into VSHP and SET's claims processing systems.

For the 100 claims processed by VSHP that were selected for testing, one discrepancy was noted. A procedure code modifier submitted on a provider claim was not entered into VSHP's claims processing system. The omission incorrectly resulted in no payment for the procedure code.

Management Comments

Management concurs. The prior processing system (Amisys) handled incorrectly.

For the 10 NEMT claims processed by SET selected for testing, two discrepancies were noted. The majority of NEMT claims are submitted by providers via a "TennCare Trip Reimbursement Form" which only reports minimal data elements. However, two claims selected for testing were submitted on a HCFA 1500 claim form which reports additional data elements beyond the "TennCare Trip Reimbursement Form" (ex: diagnosis codes). SET indicated the HCFA 1500 is used for validation purposes. SET does not record all the contractually required data elements of HCFA 1500 claims. Charges submitted by the providers do not agree to the charges recorded in SET's claims processing system.

VSHP/SoutheasTrans Comments:

Management concurs but would like to offer the following for clarification regarding the two claims submitted via HCFA claims form and related variance: SoutheasTrans correctly paid the provider the contracted amount. The ambulance provider's billing system rounds up to the nearest mile. The contract requires SoutheasTrans to pay the actual mileage. Therefore, it gives the appearance that SoutheasTrans underpaid the provider 89 cents and 91 cents on each trip. All trips are paid from a pre-negotiated rate. The claim form serves only as proof that the provider ran the trip.

F. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected. For the 100 claims processed by VSHP that were selected for testing, the following discrepancies related to adjudication accuracy were noted.

- For one claim, a service line on a claim was incorrectly denied as Medicare as primary resulting in an underpayment of $25.81.

  Management Comments

  Management concurs. This was the result of a processor error.

- As previously noted for one claim, a procedure code modifier submitted on a provider claim was not entered into VSHP's claims processing system. The

omission incorrectly resulted in no payment for the procedure code.

Management Comments

Management concurs. The prior processing system (Amisys) handled incorrectly.

- For one claim, the claim was incorrectly denied with the explanation exceeds timely filing limits. The claim should have denied with the explanation duplicate submission.

  Management Comments

  Management concurs. The prior processing system (Amisys) handled incorrectly.

For the 10 NEMT claims processed by SET selected for testing, no adjudication accuracy discrepancies were noted.

G. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts are calculated correctly.

For the 100 claims processed by VSHP that were selected for testing, the following pricing accuracy discrepancies were noted:

- For two claims, the amount paid did not agree to the contractually negotiated rate in the provider agreement resulting in an underpayment of both claims.

  Management Comments

  Management concurs. The provider agreement was modified after these claims were adjudicated. They should have been tagged for adjustment. This process has been reviewed with the configuration team.

- For one claim, the amount paid could not be traced to agreement with the provider since no rate was established in the agreement for revenue code 0451.

  Management Comments

Management concurs. While the final payment was correct, the configuration of the agreement did not display the correct pricing rule.

For the 10 NEMT claims processed by SET selected for testing, no pricing accuracy discrepancies were noted.

H. Copayment Testing

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

Because the 100 claims processed by VSHP that were selected for testing and the 10 NEMT claims processed by SET selected for testing did not include any claims with copayments calculated, examiners requested a data file from VSHP with the top enrollees with applied copayments. The data file provided included claims dates of service from April 2008 through March 2009. Review of the data file noted:

Claims for the three enrollees with highest accumulated copayments were reviewed and no problems were noted.

Additional review of the data file included determination whether copayments were not applied to preventive procedures, and copayments of emergency visits were accurately applied, and a search for unusual copayment amounts.

- The application of copayments to 14 claims related to visits to community mental health centers were incorrectly applied. The TennCare Bureau had previously informed VSHP of this issue. VSHP was in the processing of correcting errors of this type based on communications with the TennCare Bureau.

  Management Comments

  Management concurs. VSHP received an updated copay document from the Bureau of TennCare on June 23, 2009. Prior to this, the system was configured based on the copay chart contained in the Contractor Risk Agreement. Adjustments to claims were already in process at the time of this audit. FACETS configuration was updated in May to address potential confusion for processors related to the correct copay amounts for CMHCs and BHCs (behavioral health clinics). In addition, staff were educated about how to identify the correct copay amounts for the provider type.

- The application of a copayment to one claim was incorrectly applied for two service lines on a claim.

  Management Comments

Management concurs. This was the result of a system error. The adjudication system has been updated.

I. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system.

The examiners requested VSHP to provide five remittance advices selected from claims tested to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers. No discrepancies were noted between the claims payment per the claims processing system and the related information communicated to the providers.

J. Analysis of Cancelled Checks

The purpose of analyzing cancelled checks is to: (1) verify the actual payment of claims by VSHP; and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The examiners requested VSHP to provide five cancelled checks from claims tested. VSHP provided the cancelled checks for two payments and proof of electronic transfer for three payments. The check or electronic transfer amounts agreed with the amounts paid per the remittance advice and no pattern of significant lag times between the issue date and the cleared date was noted.

K. 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 December 31, 2008, were reviewed for claims which exceeded 60 days old. The pended and unpaid data files for East Tennessee, TennCare Select, and West Tennessee processed by VSHP, as well as the subcontractor, indicate only 723 claims exceed 60 days in process. No material liability exists for claims over 60 days.

L. Electronic Claims Capability

Section 2-9.m.3. of the CRA for the East Tennessee Grand Region and Section 2-1.i. of the AATS for TennCare Select state, “The CONTRACTOR shall provide the capability of electronic billing.” Section 2.22.2.2 of the CRA for the West Tennessee Grand Region states, “The CONTRACTOR shall have in place, an electronic claims

management (ECM) capability that accepts and processes claims submitted electronically..." The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II (HIPAA) requires that all health plans be able to transmit and accept all electronic transactions in compliance with certain standards as explained in the statute by October 15, 2002. The U.S. Department of Health and Human Services extended the deadline until October 15, 2003, for health plans requesting additional time. Failure to comply with the standards defined for the transactions listed can result in the assessment of substantial penalties.

VSHP accepts and processes claims submitted electronically. VSHP has implemented the necessary changes to process claims per the standards outlined in the HIPAA statutes.

M. Mailroom and Claims Inventory Controls

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

The review of mailroom and claims inventory controls by TDCI included interviews with VSHP personnel and review of the mailroom and claims processing flowcharts. A tour of the mailroom was completed and ten claims were selected in the mailroom for testing. At a later date, the received date recorded in the claims processing system was compared to the date the claims were selected by TDCI in the mailroom. For each of the ten claims selected for testing, the received date was correctly entered into the claims processing system or the claim had been rejected and returned to the provider. No additional test work of mailroom procedures was performed.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints

Provider complaints were tested to determine if VSHP responded to all provider complaints in a timely manner. Tenn. Code Ann. § 56-32-226 states:

> 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.

Seven provider complaints to VSHP and three provider complaints to SET were judgmentally selected from listings provided by VSHP. For the ten provider complaints tested, VSHP and SET responded timely to the provider. No discrepancies were noted.

B. 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. VSHP updates quarterly the provider administration manual through provider newsletters. The provider administration manual and the quarterly newsletters were submitted by VSHP and prior approved by TDCI. VSHP's provider administration manual is incorporated by reference in each of VSHP's agreement with providers. Updates to the provider administration manual amend the provider agreements and, therefore, require compliance with the requirement in the Section 2-18.cc of the CRA for the East Tennessee Grand Region and the AATS for TennCare Select, and Section 2.12.7.36 of the CRA for the West Tennessee Grand Region. These contracts require that VSHP:

> Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the provider agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the provider agreement, then the terms shall include provisions allowing at least thirty (30) calendar days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., certified mail, facsimile, hand-delivered receipt, etc);

Testing of documentation of receipt of notification of amendments to the provider administration manual noted the following:

- VSHP's documentation for 2nd Quarter updates to the Provider Administration Manual indicated that a notice was left for one provider but no confirmation of delivery was received.

- VSHP's documentation for 3rd and 4th quarter's updates to the Provider Administration Manual indicated that a notice was left for one provider but no confirmation of delivery was received.

In addition to documentation of delivery, VSHP must maintain documentation of the receipt of notification of amendments to provider agreements.

Management Comments

Management concurs. The mailing of the quarterly provider manual updates is a vended service. VSHP has obtained a new vendor for this service, FCSI. FCSI produces quality work and has better tracking for these types of issues.

C. Provider Agreements

Agreements between an HMO and medical 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 medical 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 medical provider.

Per Section 2-18. of the CRA for the East Tennessee Grand Region and the AATS for TennCare Select and Section 2.12.2 of the CRA for the West Tennessee Grand Region between VSHP and the TennCare Bureau, 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 2-18. of the CRA for the East Tennessee Grand Region and the AATS for TennCare Select and Section 2.12.8 of the CRA for the West Tennessee Grand Region report the minimum language requirements for provider agreements.

TDCI requested VSHP to provide the current TennCare electronic provider file. The provider file is utilized by the TennCare Bureau to periodically verify network adequacy requirements of VSHP. TDCI judgmentally selected 33 contracted providers varied by provider types including hospitals and behavioral health providers. TDCI requested the executed contracts be available for inspection during fieldwork.

VSHP did not mail the 2009 BlueCare Compliance Amendment to all providers. After documentation for mailing the 2009 BlueCare Compliance Amendment was requested by TDCI, VSHP discovered that the Amendment was not sent to all providers. Ancillary providers were omitted from the mailing. On June 26, 2009, VSHP mailed the Amendment to ancillary providers with an effective date of August 1, 2009.

Management Comments

Management concurs. The 2009 BlueCare Compliance Amendment was not originally sent to the Ancillary providers at the same time as other providers; however, the Ancillary providers did receive this mailing at a later date.

VSHP could not provide executed contracts for two behavioral health providers, Cherokee Health Systems and Southeast Mental Health Center, and one transportation provider, UT Lifestar, LLC. Behavioral health providers are contracted through the VSHP subcontractor, Value Options. The accuracy of the provider file submitted to TennCare is critical in determining VSHP's ability to provide the necessary services to TennCare enrollees. VSHP should verify the accuracy of the provider file and establish controls that will not allow a provider to be listed as contracted when an executed contract with VSHP or Value Options does not exist.

Management Comments

Management concurs. Contracts with CHS and SEMHC are now executed, and controls are in place to appropriately identify providers on the provider file as contracted or out of network.

Due to errors discovered in the provider file, an additional five behavioral health providers were selected for testing.

The contracts selected for testing were reviewed to determine if the executed agreements and any amendments were prior approved by TDCI. For amendments that did not require signature by both parties, testing included inspection of documentation of receipt of notification of amendments to the provider. The following discrepancies were noted:

- For two behavioral health providers, amendments to the provider agreements were not submitted to TDCI for prior approval in violation of Section 2.12.2 of the CRA for the West Tennessee Grand Region

  Management Comments

  Management concurs. Controls have been implemented to address this

issue. ValueOptions' contracting department works with the VSHP BHO program manager to ensure that any changes to contracts are vetted via VSHP Legal and Compliance. As needed, Compliance consults with TDCI regarding whether changes constitute a material change requiring submission to TDCI for review.

D. Provider Payments

Capitation payments to providers were tested during 2008 to determine if VSHP complied with the payment provisions set forth in its capitated provider agreements. Review of payments to capitated providers indicated that all payments were made per the provider contract requirements in a timely manner.

E. 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, per Section 2-9. of the CRA for East Tennessee Grand Region, Section 2.17 of the AATS for TennCare Select, and 2.26.3 of the CRA for West Tennessee Grand Region, all template subcontractor agreements and revisions thereto must 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.

The following deficiencies were noted during the review of subcontract testing:

- As previously noted, the administrative service agreements between VSHP and BCBST for the management services related to Cover Tennessee Program, MedAvantage, and other medical management services were not submitted for prior approval to TDCI a material modification.

  Management Comments

  Management concurs. We have had numerous communications with TDCI to resolve this issue, resulting in submission and approval of Administrative Services Agreements (ASAs) documenting all services between VSHP and its parent company, BCBST. The Cover Tennessee ASAs (3 total) were filed initially with TDCI on September 28, 2009, and approved by TDCI on October 20, 2009. The medical management ASA was initially filed with TDCI on March 12, 2010, but was disapproved. VSHP has subsequently worked with TDCI to update and consolidate all existing ASAs in order to streamline and consolidate these agreements. These revised ASAs were filed with TDCI on June 3, 2010 and approved June 7, 2010.

As of August 18, 2010, all revised and new ASAs have been executed by the respective officers of VSHP and BCBST with effective dates retroactive to January 1, 2008, the date that these services were first rendered and compensation exchanged between the parties.

- A subcontract to Trizetto, for claims processing services was not submitted to TDCI and TennCare for prior approval as a material modification VSHP used Trizetto to process excess volume loads of medical claims that involved the application of minimal edits. This subcontract delegates VSHP's responsibilities related to claims processing and should have been submitted to TDCI and TennCare for prior approval. It should be noted that Trizetto is an affiliate of BCBST. The claims processing software FACETS utilized by VSHP, is a product of Trizetto.

  Management Comments

  Management concurs.

F. Non-discrimination

Section 2-24. of the CRA for the East Tennessee Grand Region, Section 2-24 of the AATS for TennCare Select, and Section 2.28 of the CRA for the West Tennessee Grand Region, require VSHP to demonstrate compliance with Federal and State regulations of Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1983, Title II of the Americans with Disabilities Act of 1990, the Age of Discrimination Act of 1985 and the Omnibus Budget Reconciliation Act of 1981. Based on discussions with VSHP staff and a review of policies and related supporting documentation, VSHP was in compliance with the non-discrimination reporting requirements of the TennCare contracts.

G. 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. No deficiencies were noted in review of organization or activities of the internal audit department.

H. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., Title 56, Chapter 11, Part 2 – 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…."

As previously noted, the administrative service agreements between VSHP and BCBST for the management services related to Cover Tennessee Program, MedAvantage, and other medical management services were not submitted for prior approval to TDCI a material modification. The Holding Company Registration for the year ended December 31, 2008, failed to disclose the transactions related to these subcontracts. Subsequently September 28, 2009, the Holding Company Registration was amended to disclose the subcontracts and related transactions.

Management Comments

Management concurs. We have had numerous communications with TDCI to resolve this issue, resulting in submission and approval of Administrative Services Agreements (ASAs) documenting all services between VSHP and its parent company, BCBST. The Cover Tennessee ASAs (3 total) were filed initially with TDCI on September 28, 2009, and approved by TDCI on October 20, 2009. The medical management ASA was initially filed with TDCI on March 12, 2010, but was disapproved. VSHP has subsequently worked with TDCI to update and consolidate all existing ASAs in order to streamline and consolidate these agreements. These revised ASAs were filed with TDCI on June 3, 2010 and approved June 7, 2010.

As of August 18, 2010, all revised and new ASAs have been executed by the respective officers of VSHP and BCBST with effective dates retroactive to January 1, 2008, the date that these services were first rendered and compensation exchanged between the parties.

I. Behavioral Health Organization (BHO) Coordination

Effective July 1, 2002, Section 2-3.c.2. of the CRA for the East Tennessee Grand Region and Section 2-3.6 of the AATS for TennCare Select state that claims for covered services with a primary behavioral diagnosis code, defined as ICD 9-CM 290.xx- 319.xx, are submitted to VSHP for timely processing and payment. VSHP is required to refer unresolved disputes between the HMO and BHO to the State for a decision on responsibility after providing medically necessary services. VSHP did not have any ongoing disputes with the BHO.

For the West Tennessee Grand Region, the CRA requires VSHP to provide both medical and behavioral health services. As previously mentioned, VSHP subcontracts with ValueOptions for the provision of behavioral health services.

J. Contractual Requirements for ASO Arrangements

As previously mentioned, effective July 1, 2002, VSHP's CRA for the East Tennessee Grand Region was amended so that VSHP would operate as an ASO. As a result, the provisions tested below are requirements for transactions with dates of service on and after July 1, 2002.

1. Medical Management Policies

Section 3-10.h.2(a) of the CRA for the East Tennessee Grand Region requires VSHP to comply with the following:

> The CONTRACTOR shall reimburse providers according to reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures in effect as of April 16, 2002, for covered services as defined in Section 3-10.h.2(j), unless otherwise directed by TENNCARE, with funds deposited by the State for such reimbursement by the CONTRACTOR to the provider.

VSHP's management has confirmed compliance with the requirements described above. During testing of claims processing and provider contracts, no deviations to the requirement were noted.

2. Provider Payments

Section 3-10.h.2(b) of the CRA for the East Tennessee Grand Region states VSHP "shall release payments to providers within 24 hours of receipt of funds from the State."

Testing noted that VSHP was in compliance with this provision.

3. 1099 Preparation

Section 3-10.h.2.(c) of the CRA for the East Tennessee Grand Region states that VSHP "shall prepare and submit 1099 Internal Service Reports for all providers to whom payment is made." Based on TDCI's review, VSHP has complied with this requirement.

4. Interest Earned on State Funds

Section 3-10.h.2(d) of the CRA for the East Tennessee Grand Region states interest generated by funds on deposit for provider payments related to the non-risk agreement period shall be the property of the State. The interest amount earned on the funds reported on VSHP's monthly bank statement should be deducted from the amount of the next remittance request from the TennCare

Bureau. Based on TDCI's review, VSHP has complied with this requirement.

5. Recovery Amounts/Third Party Liability

Sections 3-10.h.2(f) and (g) of the CRA for the East Tennessee Grand Region require third party liability recoveries and subrogation amounts related to the non-risk agreement period be reduced from medical reimbursement requests of the TennCare Bureau. As third party liability and subrogation amounts are recovered, VSHP should reduce the next medical reimbursement request to the TennCare Bureau for the amounts recovered. A review of selected subrogation recoveries found that the amounts recovered were promptly recorded in the claims processing system, thereby reducing future medical reimbursement requests to the TennCare Bureau. Based on TDCI's review, VSHP has complied with this requirement.

6. Pharmacy Rebates

Section 3-10.h.2(f) of the CRA for the East Tennessee Grand Region states that pharmacy rebates collected by VSHP shall be the property of the State. The contract for pharmacy related services ended June 30, 2003. No pharmacy rebates remain due as December 31, 2008.

K. Contract to Audit Accounts

VSHP is required to submit annual audited financial statements by May 1 for the preceding calendar year. Section 2-10.h.4. of the CRA for the East Tennessee Grand Region, Section 2-10.8 of the AATS for TennCare Select, and Section 2.21.10.2 of the CRA for the West Tennessee Grand Region require such audits to be subject to prior approval of the Comptroller of the Treasury and to be submitted on the standard "Contract to Audit Accounts" agreement. The "Contract to Audit Accounts" between the Comptroller of the Treasury and the external auditor defines the standards for which the audits are to be performed. VSHP has complied with this provision.

L. Conflict of Interest

Section 4-8. of the CRA for the East Tennessee Grand Region, Section 6-8.xx of the AATS for TennCare Select, and Section 4.19 of the CRA for the West Tennessee Grand Region warrant 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 VSHP 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 CRAs 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 CRAs 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's 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 CRAs.

- The administrative service agreements between BCBST and VSHP for BlueCare and TennCare Select include the same conflict of interest language as the Contractor Risk Agreement.

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- The organizational structure of VSHP includes a Chief Compliance Officer who reports to the Board of Directors and the Board's Audit Committee.

- BCBST has an internal audit department which monitors day-to-day compliance issues as well as the performance of focused audits of Contractor Risk Agreement requirements.

- Standards for ethical guidelines have been formalized in a Code of Business Conduct for employees.

- A written compliance program has been developed to provide a mechanism to enforce the Code of Business Conduct. The compliance program includes, but is not limited to, the duties of the Chief Compliance Officer, auditing processes, and reporting violations.

Based on TDCI's review it appears that VSHP has established and implemented policies and procedures to enforce compliance with TennCare's conflict of interest requirements.

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