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 of Tennessee and
d\b\a TennCare Select

CHATTANOOGA, TENNESSEE

FOR THE PERIOD JANUARY 1, 2015
THROUGH DECEMBER 31, 2015

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TN Department of Commerce & Insurance

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DATE: January 19, 2017

The Financial and Compliance Examination and Market Conduct Examination of the TennCare Operations of Volunteer State Health Plan, Inc., Chattanooga, Tennessee, was completed August 29, 2016. The report of this examination is herein respectfully submitted.

I. FOREWORD

On March 17, 2016, the TennCare Oversight Division of the Tennessee Department of Commerce and Insurance (TDCI) notified representatives of Volunteer State Health Plan, Inc., (VSHP) of its intention to perform a Financial and Compliance Examination and Market Conduct Examination of VSHP's TennCare Operations. Fieldwork began on July 11, 2016, and ended on July 21 2016. All document requests and the signed management representation letter were provided by August 29, 2016.

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 of VSHP's policies and procedures regarding statutory and contractual requirements related to its TennCare operations. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of VSHP's TennCare operations was conducted jointly by TDCI and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller), under the authority of Section A.2.25. of the Contractor Risk Agreement for VSHP and Section 2.25 of the Agreement for the Administration of TennCare Select (AATS), Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) § 56-32-115 and § 56-32-132.

Volunteer State Health Plan, Inc., 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 Division of Health Care Finance and Administration which is a division within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

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

The current market conduct examination by TDCI and the Comptroller focused on the claims processing functions and performance for VSHP's TennCare operations.

The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.

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

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that VSHP's TennCare operations were administered in accordance with the CRA and state statutes and regulations concerning HMO operations and the AATS, 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 was incorporated under the laws of the State of Tennessee on July 11, 1996. 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 through an administrative service agreement between VSHP and BCBST.

The officers and directors or trustees for VSHP as reported on the NAIC Annual Statement for the year ending December 31, 2015, were as follows:

Officers for VSHP

Amber Jeanine Cambron, President/CEO
Toliver Ralph Woodward, Jr., Treasurer
Shelia Dian Clemons, Secretary
James Kertz Rochat, Assistant Treasurer
Katharine Anne Laurance, Assistant Secretary

Other Officers for VSHP

David Matthew Moroney, MD, VP Chief Medical Officer
James Howard Srite, Actuary
Joshua Trey White, Controller & Chief Accounting Officer
Reid Allen Smiley, VP, Chief Financial Officer
Patrick Timothy Sullivan, VP, Chief Operating Officer

Directors or Trustees for VSHP

Jason David Hickey, Chairperson
John Francis Giblin
Scott Christian Pierce

B. Brief Overview

Effective November 4, 1996, TDCI granted VSHP a certificate of authority to operate as a TennCare HMO. VSHP operated this line of business under the plan name BlueCare. VSHP or VSHP's parent organization has continually contracted with the TennCare Bureau to provide services to TennCare enrollees since the inception of the program.

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.

Effective January 1, 2015, for all regions of Tennessee, VSHP entered into an at-risk agreement with the TennCare Bureau to receive a monthly capitation payment based on the number of TennCare enrollees assigned to VSHP and each enrollee's eligibility classification.

In addition to TennCare operations, VSHP began participating in the Dual Special Needs Program (DSNP) effective January 1, 2014. Under this program, premiums for Medicare and Medicaid dual eligible members are received from the Centers for Medicare and Medicaid Services and the TennCare Bureau. As of December 31, 2015, VSHP reported Medicare enrollment of approximately 9,000 members.

Effective January 1, 2008, BCBST contracted with the State of Tennessee to administer medical services for the Cover Tennessee program which provides coverage for Tennesseans who had difficulties in accessing health insurance. BCBST contracted with VSHP through an administrative service agreement to provide medical management, outreach and education and other related services to the plans associated with Cover Tennessee. Effective January 1, 2016, and subsequent to the examination period, BCBST assigned to VSHP the responsibility of the CoverKids portion of the contract to VSHP. CoverKids offers free health coverage for pregnant women and children who do not have insurance and who do not qualify for TennCare. Additionally, effective January 1, 2016, VSHP and BCBST entered into an administrative service agreement for BCBST to provide general administrative services for VSHP's responsibility for the CoverKids program.

As of December 31, 2015, TennCare Select had approximately 73,000 TennCare members statewide and BlueCare had approximately 520,000 TennCare members. The TennCare benefits required to be provided by VSHP include:

- Medical
- Behavioral health
- Vision
- Long-term care ("CHOICES" program)
- Non-emergency transportation services

C. Claims Processing Not Performed by VSHP

During the period under examination, VSHP subcontracted with Southeastrans, Inc., (SET) for non-emergency transportation (NEMT) services and the processing and payment of related claims submitted by providers.

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

IV. SUMMARY OF CURRENT FINDINGS

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

A. Financial Deficiencies

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

B. Claims Processing Deficiencies

1. VSHP failed to achieve claims payment accuracy requirements of 97% per Section A.2.22.6 of the CRA for BlueCare Middle Grand region home and community-based services (HCBS) claims for the month of April 2015.

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

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

   - For one of the 15 claims selected for testing by TDCI that VSHP determined was accurately processed, VSHP could not demonstrate they verified the contracted rate when responding to claims payment accuracy testing attributes.

   - For the testing of claims processed by the NEMT subcontractor, VSHP could not demonstrate they verified that a duplicate payment did not occur when responding to claims payment accuracy testing attributes.

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

3. The CRA requires VSHP to self-test the accuracy of claims processing based on claims selected by TDCI on a monthly basis. For the 1,175 claims tested for the calendar year 2015, VSHP reported at least one attribute error on 161 claims during this focused claims testing.

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

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

   - One of the 36 claims selected for testing by TDCI that VSHP determined was accurately processed was for a medical service performed by an out-of-

state provider. VSHP could not demonstrate they verified the contracted rate when responding to focused claims testing attributes.

- One of the 36 claims selected for testing by TDCI that VSHP determined was accurately processed was initially denied for exceeding timely filing limits. VSHP incorrectly answered the focused claims testing attribute "Data entry is verified with hardcopy claim". The claim documentation provided reported a received date stamp of May 26, 2015. However, VSHP's claims processing system reported a received date of August 4, 2015. Additionally, TDCI noted that on October 2, 2015, VSHP reprocessed and paid this claim. However, VSHP did not provide an explanation to justify the overriding of the initial timely filing denial.

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

5. For one of five enrollees selected for copayment testing, an error was discovered in the application of copayments. VSHP incorrectly applied a copayment of $20 to one of the enrollee's claims based upon the enrollee's eligibility status.

   (See Section VI.E. of this report)

C. Compliance Deficiency

VSHP provided only a single page rate agreement between the NEMT subcontractor and a county ambulance provider. This agreement was not submitted to TDCI for prior approval as required by Tenn. Code Ann. § 56-32-103(c)(1), Section A.2.12.2 of the CRA, and Section 2.12.2 of the AATS. The agreement materially fails to meet the minimum language requirements of Section A.2.12.9 of the CRA and Section 2.12.9 of the AATS.

(See Section VII.E. of this report)

V. 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 TDCI. 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.

As of December 31, 2015, VSHP reported $805,478,036 in admitted assets, $474,646,620 in liabilities and $330,831,416 in capital and surplus on the 2015 NAIC Annual Statement submitted March 1, 2016. VSHP reported total net income of $75,212,544 on the statement of revenue and expenses. The 2015 NAIC Annual Statement and other financial reports submitted by VSHP can be found at http://tn.gov/commerce/article/tncoversight-managed-care-organization-financial-reports.

1. Capital and Surplus

a. Risk-Based Capital Requirements:

VSHP is required to comply with risk-based capital requirements for health organizations as codified in TCA § 56-46-201 et seq. VSHP has submitted a report of risk-based capital (RBC) levels as of December 31, 2015. The report calculates an estimated level of capital needs for financial stability depending upon the health entity's risk profile based on instructions adopted by the NAIC. As of December 31, 2015, VSHP maintains an excess of capital over the amount produced by the Company Action Level Events calculations required by TCA § 56-46-203. Additionally, VSHP's RBC report did not trigger a trend test as determined with trend test calculations included in the NAIC Health RBC instructions. The following table compares reported capital and surplus to the Company Action Level requirements as of December 31, 2015:

Reported Capital and Surplus	$330,831,416
Reported Authorized Control Level Risk-Based Capital	$66,761,541
Computed and Required Company Action Level Risk-Based Capital (200% of Authorized Control Level)	$133,523,082

b. HMO Net Worth Requirement:

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 for its provision of services to TennCare enrollees are to be included in the calculation of net worth and deposit requirements, regardless of the reporting requirements for the NAIC statements.

To determine the minimum net worth requirement as of December 31, 2015, TDCI utilized the total annual premium revenue earned as reported on the NAIC Annual Statement for the period ending December 31, 2015, plus TennCare Select cash payments. For the period ending December 31, 2015, VSHP reported TennCare premiums of $2,120,970,064, Medicare premiums of $76,169,034 and TennCare Select cash payments of $436,314,613 for a total of $2,633,453,711 annual premium revenue.

Utilizing $2,633,453,711 as the premium revenue base, VSHP's minimum net worth requirement as of December 31, 2015 is $43,251,806 ($150,000,000 x 4% + ($2,633,453,711-$150,000,000) x 1.5%). VSHP's reported net worth at December 31, 2015, was $287,579,610 in excess of the required minimum reported.

2. Restricted Deposit

TCA § 56-32-112(b) sets forth the requirements for VSHP's restricted deposit. VSHP's restricted deposit agreement and safekeeping receipts currently meet the requirements of TCA § 56-32-112(b). Utilizing $2,557,284,677 (reported TennCare Revenue of $2,120,970,064 plus TennCare Select cash payments $436,314,613) as the premium revenue base, VSHP's restricted deposit requirement as of December 31, 2015, is $14,000,000. VSHP has on file with TDCI, a depository agreement and properly pledged safekeeping receipts totaling $14,000,000 to satisfy restricted deposit requirements.

3. Claims Payable

VSHP reported $190,476,505 claims unpaid as of December 31, 2015. Of the total claims unpaid reported, $180,642,049 represented the claims unpaid for TennCare operations. The reported amount was certified by a statement of actuarial opinion.

Analysis by TDCI of the triangle lag payment reports through June 30, 2016, for dates of services before January 1, 2016, and review of subsequent NAIC financial filings determined that the reported claims payable for TennCare operations was adequate.

B. TennCare Operating Statements

1. TennCare Operating Statement for Non-Risk Operations for the TennCare Select Program

The AATS 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 AATS requires 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 Select is operating at-risk. As stated in Sections 2.30.16.3.3 and 2.30.16.3.4 of the AATS, 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.

2. TennCare Operating Statement for At-Risk Operations

Sections A.2.30.16.3.3 and A.2.30.16.3.4 of the CRA require each submission of NAIC financial statements to contain a separate income statement detailing the quarterly and year-to-date revenues earned and expenses incurred as a result of participation in the TennCare program.

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

C. Medical Fund Target Report

Section 2.30.16.2.1 of the AATS requires:

> The CONTRACTOR shall submit a monthly Medical Fund Target Report with cumulative year to date calculation. The CONTRACTOR shall report all medical expenses and complete the supporting claims lag tables. This report shall be accompanied by a letter from an actuary, who may be an employee of the CONTRACTOR, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy. The CONTRACTOR shall also file this report with its NAIC filings due in March and August of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report shall reconcile to NAIC filings including the supplemental TennCare income statement. The CONTRACTOR shall also reconcile the amount paid reported on the supporting claims lag tables to the amount paid for the corresponding period as reported on the CONTRACTOR's encounter file submission as specified in Sections 2.30.18.3 and 2.23.4.

The Medical Fund Target (MFT) 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 MFT. VSHP submitted monthly MFT 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 MFT estimates for IBNR expenses have been reviewed for accuracy.

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

D. Medical Loss Ratio Report

Section A.2.30.16.2.1 of the CRA requires:

> The CONTRACTOR shall submit a Medical Loss Ratio Report monthly with cumulative year to date calculation. The CONTRACTOR shall report all medical expenses and complete the supporting claims lag tables. This report shall be accompanied by a letter from an actuary, who may be an employee of the CONTRACTOR, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy. The CONTRACTOR shall also file this report with

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

VSHP submits medical loss ratio (MLR) for each at-risk region on the basis of the State's fiscal year which ends on June 30. The medical loss ratio percentage is based upon total medical payments plus incurred but not reported (IBNR) claims estimate divided by capitation revenue net of premium tax. TDCI performs an analysis of each region and for all regions combined. VSHP's MLRs for the period July 1, 2015, through December 31, 2015, were submitted February 15, 2016. Based on TDCI's analysis, the combined medical loss ratio with capitation revenue net of premium tax was 88.75% for this period. VSHP's July 2016 MLRs were submitted on August 18, 2016. Based on an analysis of VSHP's July 2016 MLRs, for the period July 1, 2015, through December 31, 2015, the combined medical loss ratio was 87.17%. The reason for the noted decrease in the MLR percentage was due to adjustments of IBNR estimates. Over time the IBNR estimates can be reduced with the submission and payment of actual claims. The procedures and supporting documents to prepare the MLR report were reviewed.

No discrepancies were noted during the review of documentation supporting the amounts reported on the MLR report.

E. Administrative Expenses and Management Agreement

For the year ended December 31, 2015, VSHP reported total Administrative Expenses of $329,570,405. Administrative expense is comprised of premium taxes of $122,739,337 on at-risk premiums, Affordable Care Act health insurer fee of $26,320,521, direct administrative expenses of $51,162,554 and allocated expenses from the parent of $129,347,993. Allocated expenses are the result of administrative and support services fees paid pursuant to the administrative services agreement between VSHP and BlueCross BlueShield of Tennessee, Inc. (BCBST). The administrative services agreement requires BCBST to perform certain administrative and support services necessary for the operation of VSHP. These services include, but are not limited to, finance, management information systems, claim administration, telephonic member and provider services support, legal, regulatory, and provider credentialing. The fees paid to 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 methodologies utilized by VSHP were reviewed by TDCI. No deficiencies were noted during the review of the management agreement.

F. Schedule of Examination Adjustments to Capital and Surplus

No adjustments are recommended to Capital and Surplus for the period ending December 31, 2015, as a result of the examination of VSHP's TennCare operations.

VI. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

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

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.
>
> > (A) "Pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.
> >
> > (B) "Process" means the health maintenance organization must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either that the claim had been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for

> denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice must specifically identify all such information and documentation.

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

Prompt Pay Results for All Claims Processed

The following table represents the results of prompt pay testing combined for all TennCare claims processed by VSHP and the NEMT subcontractor.

VSHP All TennCare Operations	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2015	95%	99.9%	**Yes**
February 2015	99%	99.9%	**Yes**
March 2015	99%	99.9%	**Yes**
April 2015	99%	99.9%	**Yes**
May 2015	98%	99.9%	**Yes**
June 2015	96%	99.9%	**Yes**
July 2015	96%	100.0%	**Yes**
August 2015	96%	100.0%	**Yes**
September 2015	96%	100.0%	**Yes**
October 2015	99%	99.9%	**Yes**
November 2015	99%	99.9%	**Yes**
December 2015	98%	100.0%	**Yes**

When combining the results for all claims processed, VSHP was in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for all months in 2015.

Prompt Pay Results for Non-Emergency Medical Transportation (NEMT) Claims

Sections A.15.3 and A.15.4, of ATTACHMENT XI to the CRA and the AATS require VSHP to comply with the following prompt pay claims processing requirements for NEMT claims:

- The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for NEMT services delivered to a member are processed within thirty (30) calendar days of the receipt of such claims.

- The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all NEMT provider claims for covered NEMT services delivered to a member.

Prompt pay testing by TDCI determined that the NEMT subcontractor, Southeastrans, Inc., processed claims in compliance with Section A.2.22.4 of the CRA and Section 2.22.4 of the AATS for all months in calendar year 2015.

Prompt Pay Results for CHOICES Claims

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

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

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

Prompt pay testing determined that BlueCare CHOICES claims were processed in compliance with Section A.2.22.4 of the CRA for all months in calendar year 2015. Prompt pay testing determined that TennCare Select CHOICES claims were processed in compliance with Section 2.22.4 of the AATS for all but four months in calendar year 2015. TDCI determined the prompt pay failures were not significant due to the minimal number of claims (less than 6 claims) processed in the noted four months.

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

B. Determination of the Extent of Test Work on the Claims Processing System

Several factors were considered in determining the extent of testing to be performed on 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,
- Review of the focused claims testing procedures and responses and,
- Review of internal controls related to claims processing.

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

C. Claims Payment Accuracy

1. Claims Payment Accuracy Reported by VSHP

Section A.2.22.6 of the CRA and Section 2.22.6 of the AATS requires that 97% of claims are processed or paid accurately upon initial submission. On a monthly basis, VSHP submits claims payment accuracy percentage reports by Grand Region and TennCare Select to TennCare based upon audits conducted by VSHP. A minimum sample of one hundred and sixty (160) claims randomly selected from the entire population of electronic and paper claims processed or paid upon initial submission for the month tested is required. Additionally, each monthly sample of one hundred and sixty (160) claims shall contain a minimum of thirty (30) claims associated with nursing facility (NF) services provided to CHOICES members and thirty (30) claims associated with home and

community-based care services (HCBS) provided to CHOICES members. The testing attributes to be utilized by VSHP are defined in the CRA and the AATS between VSHP and the TennCare Bureau. Additionally, subcontractors responsible for processing claims shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor.

VSHP performed and reported compliance with monthly claims payment accuracy requirements for all months in the calendar year 2015 except for the month of April. For April 2015, VSHP reported 95.56% claims payment accuracy for the BlueCare Middle Grand region for home and community-based services. In response to the deficiency, VSHP submitted a corrective action plan which identified a system error that caused the improper denial of certain claims as duplicate submissions. VSHP noted that a claims processing system enhancement was implemented effective July 31, 2015.

Management Comments

Management concurs. The targeted system enhancement scheduled for July 2015 did not resolve all of the issues and we continue to work towards additional solutions as issues are identified.

2. Claims Payment Accuracy Reported by the NEMT Subcontractor

ATTACHMENT XI Section A.15.5 of the CRA and the AATS requires VSHP to pay 97% of Non-Emergency Medical Transportation (NEMT) claims accurately upon initial submission. Additionally, ATTACHMENT XI Section A.15.6 of the CRA and the AATS requires an audit of NEMT claims that complies with the requirements in the CRA regarding a claims payment accuracy audit. The NEMT subcontractor, Southeastrans, Inc., performed and reported compliance with monthly claims payment accuracy requirements for all months in calendar year 2015.

3. Procedures to Review the Claims Payment Accuracy Reports

The review of the claims payment accuracy reports included an interview with responsible staff of VSHP and Southeastrans, Inc., to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy reports. The review included verification that the number of claims selected by VSHP and the NEMT subcontractor agreed to requirements of Sections A.2.22.6 and ATTCHMENT XI Section A.15.5 and A.15.6 of the CRA and Sections 2.22.6 and Attachment XI Section A.15.5 and A.15.6 of the AATS. These interviews were followed by a review of the supporting documentation used to prepare the claims payment accuracy reports.

From VSHP's and the NEMT subcontractor's December 2015 claims payment accuracy report, TDCI selected for testing all three claims reported as errors and judgmentally selected fifteen claims reported as accurately processed. For claims that were considered errors, testing focused on the type of error (manual or system) and whether the claim was reprocessed. For claims that were reported as accurately processed by VSHP, TDCI tested these claims to the attributes required in Section A.2.22.6.4 of the CRA and Section 2.22.6.4 of the AATS.

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

For the claims selected for verification from VSHP's and the NEMT subcontractor's claims payment accuracy reports, the following deficiencies were noted:

- One of the 15 claims that VSHP determined was accurately processed was for a medical service performed by an out-of-state provider. VSHP relied on a Blue Cross and Blue Shield plan in another state to process and pay this claim. The claim was paid utilizing the rate negotiated with the out of state Blue Cross and Blue Shield plan. For the following attribute, "Allowed payment amount agrees with contracted rate", VSHP could not demonstrate they verified the contracted rate when responding to claims payment accuracy testing attributes. VSHP should develop procedures to properly respond to the claims payment accuracy attribute that the payment agrees with the contracted rate for out-of-state processed and paid claims.

- VSHP procedures for testing claims processed by the NEMT subcontractor does not include a claims history search for duplicate claim payments for the same member, same date of service, and same trip occurrence. For the following attribute, "Duplicate payment has not occurred", VSHP could not demonstrate they verified that a duplicate payment did not occur when responding to claims payment accuracy testing attributes.

Management Comments

Bullet 1: Management concurs. BlueCare agrees to better define the process going forward and make improvements where necessary.

Bullet 2: Management concurs. BlueCare will work with SET to make sure that the auditing parameters around the duplicate attribute are detailed and laid out more clearly.

D. Focused Claims Testing

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

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

For monthly focused claims testing by VSHP during calendar year 2015, TDCI judgmentally selected 25 claims from each of the BlueCare East, BlueCare Middle, BlueCare West and TennCare Select prompt pay data files submitted by VSHP for prompt pay testing purposes. The focused areas for testing during calendar year 2015 included the following:

- Paid and denied medical claims
- Adjusted claims
- Claims with processing lags over 60 days
- Paid and denied CHOICES nursing facility claims
- Paid and denied CHOICES HCBS claims
- Claims processed by subcontractors
- Claims denied for exceeding timely filing limits

1. Results of Focused Claims Testing

   Each month, TDCI provided VSHP with the claims selected for testing and specified the attributes for VSHP to self-test to determine if the claims were accurately processed. For the 1,175 claims tested for the calendar year 2015, VSHP reported at least one attribute error on 161 claims. It should be noted a claim may fail more than one attribute. For the 161 claims, 242 attribute errors were reported by VSHP. The following table summarizes the focused claims testing errors reported by VSHP for the calendar year 2015:

Attribute Tested	Errors Reported by VSHP
Data Entry is Verified with Hardcopy Claim	4
Correct provider is Associated to the Claim	0
Authorization Requirements Properly Considered	43
Member Eligibility Correctly Considered	4
Payment Agrees to Provider Contracted Rate	0
TennCare Rate Reduction and Restorations Applied to Payment	0
Duplicate Payment Has Not Occurred	0
Denial Reasons Communicated to Provider Appropriate	153
Copayment Correctly Considered	0
Modifier Codes Correctly Considered	2
Other Insurance Properly Considered	9
Patient Liability Correctly Applied	0
Coding-Bundling/Unbundling Properly Considered	0
Application of Benefit Limits Properly Considered	6
Considered Benefit Limit HCBS Provided as Cost Effective Alternative	20
Application of Expenditure Cap for Member in Group 3 Considered	1
Total	242

2. Verification by TDCI of Focused Claims Testing Results

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

   - TDCI judgmentally selected 36 claims for testing in which no errors were reported by VSHP and,

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

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

   - One of the 36 claims that VSHP determined was accurately processed was for a medical service performed by an out-of-state provider. VSHP relied on a Blue Cross and Blue Shield plan in another state to process and pay this claim. The claim was paid utilizing the rate negotiated with the out of state Blue Cross and Blue Shield plan. For the following attribute, “Payment

agrees to provider contracted rate", VSHP could not demonstrate they verified the contracted rate when responding to focused claims testing attributes. VSHP should develop procedures to properly respond to the focused claims testing attribute that the payment agrees with the contracted rate for out-of-state processed and paid claims.

- One of the 36 claims that VSHP determined was accurately processed was from an out-of-state provider. The claim was correctly denied for exceeding timely filing limits for a date of service ending December 18, 2014. The claim documentation provided reported a received date stamp of May 26, 2015. However, VSHP's claims processing system reported a received date of August 4, 2015. VSHP incorrectly answered the focused claims testing attribute "Data entry is verified with hardcopy claim". Additionally, TDCI noted that on October 2, 2015, VSHP reprocessed and paid this claim. No explanation has been provided to justify the overriding of the timely filing denial.

  Management Comments

  Bullet 1: Management concurs. BlueCare agrees to better define the process going forward and make improvements where necessary.

  Bullet 2: Management concurs. BlueCare has completed additional training and stressed the importance of the accuracy of the responses to the attributes. The claim in question was adjusted in August 2016 to recover the overpayment and to accurately reflect the timely filing denial. This was a manual error.

E. Copayment Testing

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

TDCI requested from VSHP a listing of the 100 enrollees with the highest accumulated copayments for the period January 1, through December 31, 2015. From the listing, five enrollees were judgmentally selected and all of the claims processed for those enrollees in calendar year 2015 were analyzed to determine if VSHP had correctly applied copayment requirements of the CRA based upon the enrollees eligibility status. For one of five enrollees selected for copayment testing, an error was discovered in the application of copayments. VSHP incorrectly applied a copayment of $20 to one of the enrollee's claims based upon the enrollee's eligibility status.

Management Comments

Management concurs. The copay that was taken for this claim was originally based on the specialist copay. BlueCare addressed this in early 2016 by changing configuration to read the primary care physician logic for providers associated with the CMHCs.

F. Remittance Advice Testing

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

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

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

TDCI requested VSHP to provide ten cancelled checks or EFT documentation related to claims previously tested by TDCI. VSHP provided the cancelled checks or the proof of EFT. The documents provided agreed with the amounts paid per the remittance advices and no pattern of significant lag times between the issue date and the cleared date was noted.

H. Pended and Unpaid Claims Testing

The purpose of analyzing pended claims is to determine if a significant number of claims are unprocessed and as a result a material liability exists for the unprocessed claims.

The pended and unpaid data files submitted to TDCI as of July 31, 2016, were reviewed for claims which were unprocessed and exceeded 60 days old from receipt date. The pended and unpaid data file of claims unprocessed by VSHP, as well as subcontractors, indicate a total of 27,100 claims exceeding 60 days in process as of July 31, 2016. VSHP, including subcontractors, processed 1,003,520 initial submission claims for the month of July 2016, thus, it does not appear that a material liability exists for claims over 60 days old.

I. Mailroom and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls is to determine if 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.

TDCI did not perform a site visit of the mailroom operations of VSHP's subcontractor, Southeastrans, Inc., during this examination; however, TDCI performed the following procedures to review mailroom and claims inventory controls:

- Responses to internal control questionnaires regarding mailroom operations were reviewed,
- Staff of each mailroom were interviewed,
- Current mailroom processes were compared to the site visit results from the previous examination for VSHP only, and
- Flowcharts documenting mailroom processes were reviewed.

No reportable deficiencies were noted by TDCI during the review of the mailroom and claim inventory controls for VSHP and Southeastrans, Inc.

VII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints Received by VSHP

Provider complaints were tested to determine if VSHP responded to all provider complaints in a timely manner. Tenn. Code Ann. § 56-32-126(b)(2)(A) states in part:

> The health maintenance organization must respond to the reconsideration request within thirty (30) calendar days after receipt of the request. The response may be a letter acknowledging the receipt of the reconsideration request with an estimated time frame in which the health maintenance organization will complete its investigation and provide a complete response to the provider. If the health maintenance organization determines that it needs longer than thirty (30) calendar days to completely respond to the provider, the health maintenance organization's reconsideration decision shall be issued within sixty (60) calendar days after receipt of the reconsideration request, unless a longer time to completely respond

is agreed upon in writing by the provider and the health maintenance organization.

TDCI utilized VSHP's December 2015 provider complaint logs to verify the timeliness of provider complaint processing. TDCI judgmentally selected twenty-two provider complaints for testing. No deficiencies were noted in the processing of provider complaints in accordance with timeliness requirements of Tenn. Code Ann. § 56-32-126(b)(2)(A).

B. Provider Complaints Received by TDCI

TDCI offers to providers a complaint process for disputes with TennCare MCOs. Complaints may involve claims payment accuracy and timeliness, credentialing procedures, inability to contact or obtain assistance from the MCO, miscommunication or confusion around MCO policy and procedures, etc. When a provider complaint is received, TDCI forwards the complaint to the MCO for investigation. The MCO is required to respond in writing within 14 days to both the provider and TDCI to avoid assessment of liquidated damages pursuant to the "On Request" report requirements of the CRA.

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

For the period January 1 through December 31, 2015, TDCI received and processed 134 provider complaints against VSHP. The responses by VSHP to providers were categorized by TDCI in the following manner:

Previous denial or underpayment reversed in favor of the provider	72
Previous denial or payment upheld	39
Previous denial or underpayment partially reversed in favor of the provider	13
Other inquiries	3
Duplicate	1
Resolved	6

TDCI judgmentally selected 26 of these provider complaints for review. The issues raised by the providers were analyzed and questions were posed to VSHP for response. Emphasis was placed on discovering deficiencies in the VSHP's claims processing system or provider complaint procedures. For the 26 provider complaints selected for testing, no reportable issues were noted in the timely resolution of the provider complaints.

C. Independent Reviews

The independent review process was established by Tenn. Code Ann. § 56-32-126(b)(2) to resolve claims disputes when a provider believes a TennCare MCO has partially or totally denied claims incorrectly. TDCI administers the independent review process, but does not perform the independent review of the disputed claims. When a request for independent review is received, TDCI determines that the disputed claims are eligible for independent review based on the statutory requirements (i.e. the disputed claims were submitted for independent review within 365 days from the date the MCO first denied the claims). If the claims are eligible, TDCI forwards the claims to a reviewer who is not a state employee or contractor and is independent of the MCO and the provider. The decision of the independent reviewer is binding unless either party to the dispute appeals the decision to any court having jurisdiction to review the independent reviewer's decision.

For the period January 1 through December 31, 2015, 143 independent reviews were initiated by providers against VSHP. The following is a summary of the reviewer decisions:

Reviewer decision in favor of the provider	20
Settled for the provider	23
Denial Upheld	16
Previous denial or underpayment partially reversed in favor of the provider	18
Ineligible	65
Rescinded	1

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

D. Provider Manual

The provider manual outlines written guidelines to providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim. No discrepancy was noted.

During the examination period, VSHP submitted quarterly updates to the provider manual for prior approval by TDCI. A complete revision of the provider manual was approved by TDCI on June 21, 2016.

E. Provider Agreements

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

Per Section A.2.12.2 of the CRA and Section 2.12.2 of the AATS, all template provider agreements and revisions thereto must be approved in advance by TDCI, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Additionally, Section A.2.12.9 of the CRA and Section 2.12.9 of the AATS reports the minimum language requirements for provider agreements.

From the 36 claims tested above in Section VI.D., TDCI requested the executed provider agreements for testing. For one of the 36 claims, VSHP provided only a single page rate agreement between the NEMT subcontractor and a county ambulance provider. This agreement was not submitted to TDCI for prior approval as required by Tenn. Code Ann. § 56-32-103(c)(1), Section A.2.12.2 of the CRA, and Section 2.12.2 of the AATS. The agreement materially fails to meet the minimum language requirements of Section A.2.12.9 of the CRA and Section 2.12.9 of the AATS.

Management Comments

Management concurs. While the rate sheet for this ambulance provider was based upon the rate sheet template approved most recently in ABACUS Matter 15-344, the details (trip type, mileage rate applicability, and comments) were drafted to be applicable to an ambulance provider. BlueCare Tennessee will submit the ambulance provider rate sheet to TDCI for approval as a material modification.

F. Provider Payments

Capitation payments to providers were tested during 2015 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.

G. Subcontracts

HMOs are required to file notice and obtain the Commissioner's approval prior to any material modification of operational documents in accordance with Tenn. Code Ann. § 56-32-103(c)(1). Additionally, Section A.2.26.3 of the CRA and Section 2.26.3 of the AATS requires all subcontractor agreements and revisions thereto be approved in advance in writing by TDCI, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof.

Two subcontract agreements were tested to determine the following: (1) that the contract templates were prior approved by TDCI and the TennCare Bureau and (2) that the executed agreements were on approved templates. No deficiencies were noted during the review of the subcontracts selected for testing.

H. Subcontractor Monitoring

The CRA between VSHP and the TennCare Bureau allows VSHP to delegate activities to a subcontractor. VSHP is required to reduce subcontractor agreements to writing and specify the activities and report responsibilities delegated to the subcontractor. VSHP should monitor the subcontractor's performance on an ongoing basis. Also, VSHP should identify any deficiencies or areas for improvement and determine the appropriate corrective action as necessary. Section A.2.26.1 of the CRA and Section 2.26.1 of the AATS states, "If the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6." Additionally, Section A.2.26.7 of the CRA and Section 2.26.7 of the AATS require VSHP to ensure that subcontractors comply with all applicable requirements of the CRA and the AATS, respectively. Federal and state requirements include, but are not limited to, specific regulations regarding non-discrimination, conflicts of interest, lobbying, and offer of gratuities.

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

I. Non-discrimination

Section A.2.28 of the CRA and Section 2.28 of the AATS requires 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 1973, Title II of the Americans with Disabilities Act of 1990, the Age of Discrimination Act of 1975, and the Omnibus Budget Reconciliation Act of 1981. Based on discussions with various VSHP staff and a review of policies and related supporting documentation, VSHP

was in compliance with the reporting requirements of Section A.2.28 of the CRA and Section 2.28 of the AATS.

J. Internal Audit Function

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

The Internal Audit Department of VSHP's parent company, BlueCross BlueShield of Tennessee Inc., performs engagements of VSHP specific to its TennCare operations. Additionally, the Internal Audit Department performs monthly claims payment accuracy testing in compliance with Section A.2.21.10 of the CRA and Section 2.21.10 of the AATS. The results of the specific engagements and results of monthly claims payment accuracy testing by the Internal Audit Department were considered by TDCI during the current examination.

K. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., Title 56, Chapter 11, Part 1 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-105 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner…." VSHP is domiciled in the State of Tennessee and therefore the filing is regulated in Tennessee. No discrepancies were noted in the annual holding company registration filing for VSHP received in 2016 for the calendar year 2015.

L. Health Insurance Portability and Accountability Act (HIPAA)

Section A.2.27 of the CRA and Section 2.27 of the AATS requires VSHP to comply with requirements of the Health Insurance Portability and Accountability Act of 1996, including but not limited to the transactions and code set, privacy, security, and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data partner situations required under the regulations.

VSHP and subcontractor's information systems policies and procedures were reviewed in relation to the HIPAA requirements of the CRA and the AATS. No

deficiencies were noted during the review of policies and procedures related to HIPAA requirements.

M. Conflict of Interest

Section E.28 of the CRA and Section 5.19 of the AATS warrants that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to 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 CRA were expanded to require an annual filing certifying that the MCO is in compliance with all state and federal laws relating to conflicts of interest and lobbying.

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

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 and the AATS conflict of interest clauses in all subcontracts, provider agreements and any and all agreements that result from the CRA and the AATS.

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

- The most recently approved provider agreement templates contain the conflict of interest language of the CRA and the AATS.
- The organizational structure of VSHP includes a compliance officer who reports to the President/CEO.
- VSHP has written conflict of interest policies and procedures in place.
- The written policies and procedures outline steps to report violations.
- Employees complete conflict of interest certificates of compliance annually per the written policy and procedures.

- Internal audits are performed to determine compliance with the conflict of interest requirements of the TennCare CRA and the AATS.

TDCI noted no material instances of non-compliance with conflict of interest requirements for VSHP during the examination test work.

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

Appendix

Previous Examination Findings

The previous examination findings are provided for informational purposes. The following were financial, claims processing and compliance deficiencies cited in the examination by TDCI for the period January 1 through December 31, 2013:

A. Financial Deficiencies

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

B. Claims Processing Deficiencies

1. The claims processing subcontractor for DME claims, CareCentrix Inc., failed to achieve monthly compliance with prompt pay standards for the processing of DME claims for seven months in the East Tennessee Grand Region, for six months in the West Tennessee Grand Region and for eight months for the TennCare Select contract for the calendar year ending December 31, 2013. It should be noted that the contract with CareCentrix Inc., ended for dates of service October 31, 2012, and prompt pay testing for claims run-out purposes ended for CareCentrix Inc., in November 2013.

2. VSHP reported a 96% claims payment accuracy rate for BlueCare long term care nursing facility claims in the West Grand Region for the month of November 2013 which fails to achieve the claims payment accuracy requirements of 97% as required by Section 2.22.6 of the CRAs.

3. The subcontractor, Southeastrans, Inc., reported NEMT claims payment accuracy percentages of 94% for June 2013 and 95% for August 2013 for the TennCare Select operations which fails to achieve the 97% claims payment accuracy required by ATTACHMENT XI Section A.15.5 of the AATS.

4. The review of the claims payment accuracy report testing procedures and results for December 2013 noted the following deficiencies:

   - Section 2.22.6.4.5 of the CRAs and of the AATS requires VSHP to determine if the allowed payment agrees with the contracted rate. VSHP's claims payment accuracy testing procedures do not confirm the allowed payment to the amount defined in the providers' contract for each claim tested.

- For one outpatient claim, the amount paid by VSHP for a triage fee could not be verified to the payment terms or fee schedules in the executed provider contract.
- The claims payment accuracy percentage for December 2013 was erroneously reported because VSHP failed to properly consider a claim that had been processed in error. VSHP should ensure identified errors are properly considered and reported on the claims payment accuracy reports.

5. The CRAs and the AATS include additional monthly focused claims testing requirements for VSHP to self-test the accuracy of claims processing based on claims selected by TDCI. For the 900 claims tested for the calendar year 2013, VSHP reported at least one attribute error on 91 claims.

6. During the review of the errors identified as a result of focused claims testing, TDCI noted the following significant claims processing system issues:

   a. The claims system did not always properly consider retro-active eligibility before denying claims which exceeded timely filing limits.

   b. Several claims were incorrectly denied for exceeding timely filing limits. VSHP noted that pro-active reports are utilized to detect claims that potentially will be incorrectly denied for exceeding timely filing limits before final processing. However, VSHP noted the pro-active reports failed to identify these claims and the report criteria should be updated to ensure all affected claims are captured.

   c. The following significant claims adjudication issues related to CHOICES claims submitted via the separate Electronic Visit Verification system (EVV) were noted by TDCI:

      - Several claims were incorrectly denied for lack of prior authorization. The error occurred because VSHP incorrectly applied service units based upon a file provided by the TennCare Bureau.

      - VSHP communicates the procedure code and the modifier to the EVV system based upon the enrollee's plan of care. The provider has the ability to change the modifier in the EVV system and therefore perform a service not authorized in the enrollee's plan of care.

      - The authorizations granted in VSHP's claims processing system are not always in agreement with the authorizations loaded in the EVV system. VSHP indicated that duplicate authorizations may be loaded into the EVV system instead of being replaced by updated authorizations in the EVV system causing billing errors. As a result of the error, providers are

able to provide and bill for services not in agreement with the enrollee's plan of care.

- VSHP incorrectly denied claims for exceeding authorized service units granted because of an unknown issue with the claims processing system software, Trizetto.

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

   a. For four claims in the January 2013 and two claims in the April 2013 focused claims testing, TDCI noted VSHP communicated to providers vague reasons in explanation for denied claims. "The provider must refer to the billing guidelines for proper billing" is an example of a vague reason given for the denial of a claim.

   b. For one claim in the February 2013 and two claims in the May 2013 focused claims testing, VSHP failed to submit the claims as encounter data to the TennCare Bureau. VSHP indicated encounter data submission issues occurred because the claims involved coordination of benefits.

   c. For one paid claim in the December 2013 focused claims testing, VSHP failed to submit the claim as encounter data to the TennCare Bureau. VSHP indicated that the paid claim could not be submitted as encounter data because it failed a compliancy check where the claim's reported from/through dates did not agree with the total days billed per the service lines.

8. TDCI reviewed 25 no error claims reported by VSHP during focused claims testing for calendar year 2013. For two outpatient claims, TDCI noted the amount paid by VSHP for a triage fee could not be verified to the payment terms or fee schedules in the executed provider contract. VSHP responded incorrectly to the testing attribute "Payment Agrees to Provider Contracted Rate" for these two claims.

9. TDCI reviewed the 91 error claims reported by VSHP during focused claims testing for calendar year 2013. TDCI noted four claims were not reprocessed because VSHP later determined the claims were not originally processed in error. VSHP should more carefully review responses to monthly focused claims testing results.

C. Compliance Deficiencies

For three of the nineteen provider appeals selected for testing by TDCI, VSHP did not respond to the provider with an acknowledgement letter that the complete

response would require more than 30 days in violation of Tenn. Code Ann. § 56-32-126(b)(2)(A). Additionally for these three appeals, VSHP did not seek to reach an agreement in writing with the provider that the resolution of these complaints would take longer than 60 days to complete in violation of Tenn. Code Ann. § 56-32-126(b)(2)(A). Further, two of the three provider appeals remained unresolved as of the beginning of examination fieldwork on June 9, 2014.

Finding B.4's first bullet has been repeated in the current examination. Also, findings similar to B.2 and B.5 have been repeated in the current examination.