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

Wellpoint Tennessee, Inc.
(formally known as AMERIGROUP Tennessee, Inc.)

NASHVILLE, TENNESSEE

FOR THE PERIOD JANUARY 1, 2022
THROUGH DECEMBER 31, 2022

TABLE OF CONTENTS

I. FOREWORD

II. PURPOSE AND SCOPE

III. PROFILE

IV. SUMMARY OF CURRENT FINDINGS

V. DETAIL OF TESTS CONDUCTED - FINANCIAL ANALYSIS

VI. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING

VII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

Appendix – Previous Examination Findings

TO:	Carter Lawrence, Commissioner Tennessee Department of Commerce and Insurance
	Stephen Smith, Deputy Commissioner Tennessee Department of Finance and Administration, Division of TennCare
VIA:	Toby Compton, Deputy Commissioner Tennessee Department of Commerce and Insurance
	Maya Angelova, CPA, Assistant Director Office of the Comptroller of the Treasury Division of State Audit
	Lisa R. Jordan, CPA, Assistant Commissioner Tennessee Department of Commerce and Insurance
	John Mattingly, CPA, TennCare Examinations Director Tennessee Department of Commerce and Insurance
CC:	Jim Bryson, Commissioner Tennessee Department of Finance and Administration
FROM:	Gregory Hawkins, CPA, TennCare Examinations Manager Karen Degges, CPA, Legislative Audit Manager Jessica Barker, CPA, Legislative Auditor Elyse Bellamy, Legislative Auditor Jeffery Kelly, CPA, TennCare Examiner Ronald Crozier, TennCare Examiner Laurel Hunter, CPA, TennCare Examiner Christine Tyus, CPA, TennCare Examiner
DATE:	March 26, 2024

The Financial and Compliance Examination and Market Conduct Examination of the TennCare Operations of Wellpoint Tennessee, Inc. (formally known as AMERIGROUP Tennessee, Inc.), Nashville, Tennessee, was completed September 29, 2023.The report of this examination is herein respectfully submitted.

I. FOREWORD

On April 13, 2023, the TennCare Oversight Division of the Tennessee Department of Commerce and Insurance (TDCI) notified representatives of Wellpoint Tennessee, Inc., (WLP) of its intention to perform a Financial and Compliance Examination and Market Conduct Examination of WLP's TennCare Operations. Fieldwork began on July 10, 2023, and ended on September 29, 2023. All document requests and the signed management representation letter were provided by September 29, 2023.

This report includes the results of the market conduct examination "by test" of the claims processing system for WLP's TennCare operations. Further, this report reflects the results of an examination of financial statement account balances as reported for TennCare operations by WLP. This report also reflects the results of a compliance examination of WLP'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 WLP'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 (CRA) between the State of Tennessee and WLP, Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) § 56-32-115 and § 56-32-132.

Wellpoint Tennessee, Inc. (formally known as AMERIGROUP Tennessee, 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 Division of TennCare within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The financial examination focused on selected balance sheet accounts and the TennCare income statement submitted with its National Association of Insurance Commissioners (NAIC) Annual Statement for the year ending December 31, 2022.

The current market conduct examination by TDCI and the Comptroller focused on the claims processing functions and performance for WLP 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 WLP'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 WLP's TennCare operations were administered in accordance with the CRA and state statutes and regulations concerning HMO operations, thus reasonably assuring that WLP's TennCare enrollees received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether WLP met certain contractual obligations under the CRA and whether WLP was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-101 *et seq.*;

- Determine whether WLP 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 WLP's TennCare operations properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether WLP's TennCare operations had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and

- Determine whether WLP had corrected deficiencies outlined in prior TDCI examinations of WLP's TennCare operations.

III. PROFILE

A. Administrative Organization

Wellpoint Tennessee, Inc. (formally known as AMERIGROUP Tennessee, Inc.) was incorporated under the laws of the State of Tennessee on April 26, 2006. Wellpoint Tennessee, Inc. (WLP) was licensed as an HMO by TDCI on March 29, 2007, for the purpose of participating as an MCO in the TennCare program. WLP is a wholly owned subsidiary of Wellpoint Corporation, which in turn is a wholly owned subsidiary of ATH Holding Company LLC., which in turn is a wholly owned

subsidiary of Elevance Health, Inc. (formally known as Anthem, Inc.). Elevance Health, Inc. is a publicly held company trading on the New York Stock Exchange.

The officers and directors or trustees for WLP as reported on the NAIC Annual Statement for the year ending December 31, 2022, were as follows:

Officers for WLP

Robert Thomas Garnett, President/CEO
Jennifer Ann Dewane, Vice president
Vincent Edward Scher, Treasurer
Kathleen Susan Kiefer, Secretary

Other Officers for WLP

Eric (Rick) Kenneth Noble, Assistant Treasurer
William Gregory Cannella, Medical Director

Directors or Trustees for WLP

Kristen Louise Metzger, Chairperson
Robert Thomas Garnett
Jack Louis Young

B. Brief Overview

Since April 1, 2007, WLP has been contracted through an at-risk agreement with the Division of TennCare to receive monthly capitation payments based on the number of enrollees assigned to WLP and each enrollee's eligibility classification.

As of December 31, 2022, WLP had approximately 517,000 TennCare members state-wide. The TennCare benefits required to be provided by WLP are:

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

Effective March 1, 2010, the CRA between WLP and the Division of TennCare was amended for the implementation of the CHOICES program. CHOICES is TennCare's program for long-term care services. Long-term care services include care in a nursing home and certain services to help a person remain at home or in the community. Home and Community Based Services (HCBS) are services that include help doing everyday activities that enrollees may no longer be able to do for

themselves as they grow older or if they have a physical disability that prevents them from bathing, dressing, getting around their home, preparing meals, or doing household chores. As of December 31, 2022, WLP had approximately 8,000 enrollees assigned to the CHOICES program.

Effective July 1, 2016, WLP began offering services through the Employment and Community First CHOICES program. ECF CHOICES is a program for people of all ages who have an intellectual or developmental disability (I/DD). Services in the program will help people with I/DD live as independently as possible at home or in the community, not in an institution. If the person lives at home with their family, the services help their family support them to become as independent as possible, work, and actively participate in their communities. Benefits include self-advocacy supports for the person and for their family. Residential services are also covered for adults who need them. As of December 31, 2022, WLP had approximately 800 enrollees in the Employment and Community First CHOICES program.

Effective January 1, 2021, WLP administers the CoverKids program through an at-risk arrangement with TennCare. The Children's Health Insurance Program (CHIP) is a federally sponsored program that provides health insurance to uninsured children. In Tennessee, this program is called CoverKids and includes children under age 19 and eligible mothers of unborn children who do not qualify for TennCare but meet certain income limits. For the year ending December 31, 2022, WLP had approximately 13,300 CoverKids enrollees in Tennessee.

C. Claims Processing Not Performed by WLP

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

- EyeQuest, which is a product of DentaQuest USA Insurance Company, Inc., for vision benefits and the processing and payment of related claims submitted by vision providers.

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

Because the Division of TennCare has contracted with other organizations for the provision of dental and pharmacy benefits, WLP 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 on each finding can be found in Sections V, VI, and VII of this examination report.

A. Financial Deficiencies

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

B. Claims Processing Deficiencies

1. Prompt pay testing by TDCI determined that TennCare Operations claims were not processed in compliance with Section A.2.22.4 of the CRA for the month of December 2022.

   (See Section VI.A. of this report)

2. Prompt pay testing by TDCI determined that nursing facility and CHOICES HCBS claims were not processed in compliance with Section A.2.22.4 of the CRA for the month of September 2022.

   (See Section VI.A. of this report)

3. Prompt pay testing determined that ECF CHOICES HCBS claims were not processed in compliance with Section A.2.22.4 of the CRA for August, September, and October of 2022.

   (See Section VI.A. of this report)

4. WLP failed to achieve claims payment accuracy requirements of 97% per Section A.2.22.6 of the CRA for:

   - TennCare in January 2022 and July 2022 for the Middle Region and March 2022 for the East Region.
   - Nursing Facilities in December 2022 for the Middle Region.
   - ECF CHOICES HCBS in May 2022 for the Middle Region.

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

5. The CRA requires WLP to self-test the accuracy of claims processing based on claims selected by TDCI on a monthly basis (Focused Claims Testing). For the 1,200 claims tested for calendar year 2022, WLP reported at least one attribute error on 108 claims during focused claims testing.

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

6. During the review of focused claims testing results, TDCI noted five significant claims processing deficiencies that affected the processing of 31,043 claims. Details of the additional deficiencies are described in this report.

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

7. The following deficiencies were noted by TDCI during the reverification testing of 55 claims in which WLP reported no errors during their focused claims testing results:

   - For one TennCare claim, WLP incorrectly responded to the focused claims attributes. The attribute was answered “Yes”; however, the attribute should have been answered “No” because WLP selected the incorrect provider ID.

   - For one TennCare claim, WLP incorrectly responded to the focused claims attributes. The attribute was answered “Yes”; however, the attribute should have been answered “No” because of a manual error by the claims adjudicator where benefits were not properly coordinated with other insurance.

   - For one CoverKids claim, WLP incorrectly responded to the focused claims attributes. The attribute was answered “Yes”; however, the attribute should have been answered “No” because of a manual error by the claims adjudicator where benefits were not properly coordinated with other insurance.

   - For one non-emergency transportation claim, WTP incorrectly responded to the focused claims attribute. The attribute was answered “Yes”; however, the attribute should have been answered “No” because of a manual error by the claims adjudicator where benefits were not properly coordinated with other insurance.

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

8. The following deficiencies were noted by TDCI during the reverification testing of 47 TennCare and 17 CoverKids claims in which WLP reported errors during their focused claims testing results.

   - For one claim reported as an error, WLP had not reprocessed and corrected the claim as of fieldwork during July 2023.

   - For one claim reported as an error, WLP incorrectly responded to the focus claims attributes “Denial Reasons Communicated to Provider Appropriate” and "Other Insurance Properly Considered". WLP reprocessed and paid the claim, and after further review, WLP determined that the claim was originally

processed correctly. WLP reprocessed and recovered the paid amount in April 2022.

- For two claims reported as errors, WLP did not pay the correct providers. The claims were reprocessed to pay the correct provider in January 2023. However, WLP failed to recoup the payments to the incorrect providers.

- For one CoverKids claim reported as an error, WLP failed to take a copayment. WLP reprocessed the claim in June 2022 to take a copayment. However, the claim was reprocessed again in August 2022 to give the copayment back. WLP should have taken a copayment on this claim. As of July 2023, the claim had not been reprocessed and corrected.

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

9. For four of the five TennCare enrollees selected for copayment testing, WLP failed to properly apply copay requirements based on the enrollee's eligibility status. Additionally, for one of the three CoverKids enrollees selected for copayment testing, WLP failed to properly apply copay requirements based on the enrollee's eligibility status.

   (See Section VI.E)

C. <u>Compliance Deficiencies</u>

1. For the test month of December 2022, the following deficiencies were noted in review of WLP's claim processing provider complaint log:

   - Five provider reconsideration requests tested were not resolved within 60 days of receipt. No written agreement was executed between the providers and WLP to allow additional time to resolve the reconsideration requests. Per Tenn. Code Ann section 56-32-126(b)(2)(A), " 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."

   - For two of the provider reconsideration requests, the resolution date was incorrectly recorded on the log. The resolution date did not match the date on the resolution letter sent to the provider by WLP.

   - For three reconsideration requests not resolved within 30 calendar days of receipt, WLP failed to inform the provider in an acknowledgement letter that a decision would be made within 60 calendar days of receipt. WLP policies and procedures and Tennessee Code Annotated require WLP to respond to reconsideration requests within 30 calendar days of the receipt of the request.

- For four of the provider reconsideration requests selected for testing, it was determined during TDCI's review that WLP incorrectly denied the claims on initial processing. Upon submission as a provider reconsideration request, WLP upheld its initial decision and continued to deny the claims. WLP's claim appeal procedures failed to properly determine the claims had been incorrectly denied.

- For one appeal, the resolution letter by WLP indicated the claim would be reprocessed; however, the claim had not been reprocessed as of TDCI's review on July 17, 2023.

(See Section VII.A. of this report)

2. During the testing of provider complaints submitted to TDCI, the following 21 deficiencies were noted during the review of WLP's provider complaint process:

- Sixteen claims were denied incorrectly upon initial submission by the provider. The providers submitted the claims for reconsideration, however WLP failed to overturn the incorrect denials.

- Three claims were submitted as reconsideration requests to WLP. The plan failed to process the request within 60 days as required by Tenn. Code Ann. § 56-32-126(b)(2)(A). The significant delay in the processing of reconsideration request resulted in the provider having to submit provider complaints to TDCI.

- One claim was denied with the explanation reason, "dismissed due to the claims still pending a final disposition." The denial reason is not appropriate since it does not communicate a final resolution of the claim or why the claim continues to be denied. The inappropriate denial reason resulted in the provider having to submit a provider complaint to TDCI.

- One claim was incorrectly denied upon initial submission because WLP did not associate the service to a properly received prior authorization. The reconsideration request submitted by the provider was upheld because the reconsideration was not submitted timely per WLP guidelines. After submission to TDCI as a provider complaint, WLP overturned the denial for good cause.

(See Section VII.B. of this report)

3. During the provider agreements testing, 10 agreements had the follow deficiencies noted by TDCI:

- For three WLP provider agreements, the executed agreements did not utilize the provider agreement templates most recently approved by TDCI.
- For one WLP provider agreement, an amendment was executed but was not submitted to TDCI for prior approval.
- For two WLP provider agreements, rate sheets were executed but were not submitted to TDCI for prior approval.
- For one WLP provider agreement, the agreement had been correctly submitted to TDCI for prior approval; however, WLP executed the agreement before TDCI issued an approval.
- For two EyeQuest provider agreements, the executed agreements had not been submitted to TDCI for prior approval. Additionally, during the claims processing operations review for EyeQuest, TDCI noted an executed provider agreement was never submitted to TDCI for prior approval.
- For one Tennessee Carriers provider agreement, the updated fee schedule was not submitted to TDCI for prior approval.

(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, WLP 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 WLP 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, 2022, WLP reported $1,229,109,188 in admitted assets, $914,932,379 in liabilities and $314,176,809 in capital and surplus on the 2022 Annual Statement submitted March 1, 2023. WLP reported total net income of $107,460,216 on the statement of revenue and expenses. The 2022 Annual Statement and other financial reports submitted by WLP can be found at https://www.tn.gov/commerce/tenncare-oversight/reports/managed-care-organization-financial-reports.html.

1. Capital and Surplus

   a. Risk-Based Capital Requirements:

   WLP is required to comply with risk-based capital requirements for health organizations as codified in TCA § 56-46-201 et seq. WLP has submitted a report on risk-based capital (RBC) levels as of December 31, 2022. 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, 2022, WLP maintains an excess of capital over the amount produced by the Company Action Level Events calculations required by TCA § 56-46-203. Additionally, WLP'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, 2022:

Reported Capital and Surplus	$314,176,809
Reported Authorized Control Level Risk-Based Capital	$84,212,353
Computed Company Action Level Risk-Based Capital (300% of Authorized Control Level)	$252,637,059

   b. HMO Net Worth Requirement:

   Tenn. Code Ann. § 56-32-112(a)(2) requires WLP to establish and maintain a minimum net worth equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150 million of annual premium revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of $150 million for the prior calendar year.

   Tenn. Code Ann. § 56-32-112(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions of the federal Social Security Act (title XIX), and regulations promulgated pursuant thereto, or pursuant to any other federal law as adopted by amendment to the required title XIX state plan..." Based on this definition, all TennCare payments made to an HMO for its provision of services to TennCare enrollees are to be included in the calculation of net worth and deposit requirements, regardless of the reporting requirements for the NAIC statements.

   Section A.2.21.6.1 of the CRA requires WLP to establish and maintain the minimum net worth requirements required by TDCI, including but not limited to Tenn. Code Ann. § 56-32-112.

To determine the minimum net worth requirement as of December 31, 2022, TDCI utilized the greater of (1) the total annual premium revenue earned as reported on the NAIC Annual Statement for the period ending December 31, 2022, or (2) the total cash payments made to WLP by the Division of TennCare plus premium revenue earned from non-TennCare operations for the period ending December 31, 2022.

(1) For the period ending December 31, 2022, WLP reported total company premium revenues of $2,473,498,220 on the 2022 NAIC Annual Statement (Schedule T total).

(2) For the period ending December 31, 2022, WLP reported total payments from the Division of TennCare of $2,698,163,459 and all other premiums and consideration of $442,222,965 (Schedule T total minus TN Medicaid), for a total of $3,140,386,424.

Utilizing $3,140,386,424 as the premium revenue base, WLP's minimum net worth requirement as of December 31, 2022, is $50,855,796 ($150,000,000 x 4% + ($3,140,386,424 -150,000,000) x 1.5%). WLP's reported net worth at December 31, 2022, was $263,321,013 in excess of the required minimum.

2. Restricted Deposit

TCA § 56-32-112(b) sets forth the requirements for WLP's restricted deposit. WLP's restricted deposit agreement and safekeeping receipts currently meet the requirements of TCA § 56-32-112(b). Utilizing all Tennessee earned revenue, the premium revenue base is $3,140,386,424. WLP's calculated restricted deposit requirement as of December 31, 2022, is $16,950,000. As of December 31, 2022, WLP had on file with TDCI, a depository agreement and properly pledged safekeeping receipts totaling $17,366,000 to satisfy restricted deposit requirements.

3. Claims Payable

WLP reported $297,089,932 claims unpaid as of December 31, 2022. The reported amount was certified by a statement of actuarial opinion.

Analysis by TDCI of the triangle lag payment reports through June 30, 2023, for dates of services before January 1, 2023, and review of subsequent NAIC financial filings determined that the reported claims payable for TennCare operations was adequate.

B. TennCare Operating Statement

Sections A.2.30.16.3.3 and A.2.30.16.3.4 of the CRA require each submission of NAIC financial statements to contain a separate income statement detailing the quarterly and year-to-date revenues earned and expenses incurred as a result of participation in the TennCare program. For the year ended December 31, 2022,

WLP's TennCare Operating Statement reported Total Revenues of $2,141,107,145, Medical Expenses of $1,706,786,585, Administrative Expenses of $306,203,229, Income Tax Expense of $28,647,360 and Net Income of $99,469,971.

No reportable deficiencies were noted in the preparation of the TennCare Operating Statements for the period ending December 31, 2022. The TennCare Operating Statements are separate schedules in the WLP 2022 NAIC Annual Statement which can be found at https://www.tn.gov/commerce/tenncare-oversight/reports/managed-care-organization-financial-reports.html

C. Medical Loss Ratio Report

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

WLP submits medical loss ratio (MLR) reports for each region on the basis of the State's fiscal year which ends on June 30. The MLR percentage is based upon total medical payments plus 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. WLP's MLRs for the period July 1, 2022, through December 31, 2022, were submitted January 20, 2023. Based on TDCI's analysis, the combined medical loss ratio with capitation revenue net of premium tax was 92.8% for this period. WLP's June 2023 MLRs were submitted on July 20, 2023. Based on an analysis of WLP's June 2023 MLRs for the period July 1, 2022, through December 31, 2022, the combined medical loss ratio was updated to 89.9%. The reason for the decrease in the MLR percentage was due to adjustments of IBNR estimates. Over time the IBNR estimates can be reduced with the submission and payments of actual claims.

WLP submits MLR reports for CoverKids on the basis of the State's fiscal year which ends on June 30. The MLR percentage is based upon total medical payments plus the incurred but not reported (IBNR) claims estimate divided by capitation revenue net of premium tax. TDCI performs an analysis of CoverKids. CoverKids MLR for the period July 1, 2022, through December 31, 2022, was submitted January 20, 2023. Based on TDCI's analysis, the MLR with capitation revenue net of premium tax was 96.3% for this period. WLP's CoverKids June 2023 MLRs were submitted on July

20, 2023. Based on an analysis of WLP's CoverKids June 2023 MLRs, for the period July 1, 2022, through December 31, 2022, the MLR was 97.1%. The reason for the Increase in the MLR percentage was due to adjustments of IBNR estimates. Over time the IBNR estimates can be Increased with the submission and payments of actual claims.

D. Administrative Expenses and Management Agreement

For the year ended December 31, 2022, WLP reported total administrative expenses of $360,481,270 which included direct expenses incurred by WLP and administrative and support services fees paid pursuant to the management agreement between WLP and Elevance Health, Inc. Administrative expenses represented approximately 14.58% of total premium revenue.

Effective January 1, 2014, the company entered into an administrative services agreement with its affiliated companies which the Department approved on February 20, 2014. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The costs and expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Direct costs include expenses such as salaries, employee benefits, communications, advertising, consulting services, maintenance, rent utilities, and supplies which are directly attributable to the Company's operations. Allocated costs include expenses such as salaries, benefit claims and enrollment processing, billings, accounting, underwriting, product development and budgeting, which support the Company's operations. These costs are allocated based on various utilization statistics. The fees paid to Elevance Health, Inc. are based upon a cost allocation method consistent with NAIC Statement of Statutory Accounting Principles (SSAP) No. 70.

SSAP 70 recognizes that an entity may operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, shall be apportioned to the entities incurring the expense as if the expense had been paid solely by the incurring entity. The apportionment shall be completed based upon specific identification to the entity incurring the expense. Where specific identification is not feasible apportionment shall be based upon pertinent factors or ratios.

For the year ended December 31, 2022, management fees/allocated expenses of $201,469,193 were charged to WLP by Elevance Health Inc. The management fee represented approximately 8.15% of total premium revenue.

The management agreement was previously approved by TDCI and the Division of TennCare. The allocation methodologies utilized by WLP to determine administrative expenses were reviewed by TDCI. No deficiencies were noted during the review of the management agreement.

VI. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

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

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

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

compliance with prompt pay standards for twelve months after the month of failure to avoid the penalty.

Prompt Pay Results for All Claims Processed

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

WLP All TennCare Operations	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2022	100%	99.9%	**Yes**
February 2022	100%	99.9%	**Yes**
March 2022	100%	100%	**Yes**
April 2022	100%	100%	**Yes**
May 2022	100%	99.9%	**Yes**
June 2022	100%	99.9%	**Yes**
July 2022	99%	99.9%	**Yes**
August 2022	100%	99.9%	**Yes**
September 2022	99%	99.8%	**Yes**
October 2022	99%	99.8%	**Yes**
November 2022	99%	99.8%	**Yes**
December 2022	98%	99.3%	**No**

WLP was in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for all months in 2022 except for December 2022. WLP submitted to TDCI a corrective action plan for non-compliance with Section A.2.22.4 of the CRA for the month of December 2022. The corrective action plan was reviewed by TDCI and deemed sufficient. Additionally, TDCI levied an administrative penalty of $10,000 for December 2022 non-compliance. Subsequent to the examination period, the plan was not in compliance for the month of February 2023 and another administrative penalty of $10,000 was levied.

Management Comments

Wellpoint management concurs with the findings and as mentioned above a Corrective Action Plan was submitted for the December 2022 non-compliant prompt pay file.

Prompt Pay Results for Vision Claims

Prompt pay testing determined that vision claims processed by the vision subcontractor, EyeQuest, Inc., were in compliance with Section A.2.22.4 of the CRA and Tenn. Code Ann. § 56-126(b)(1) for all months in calendar year 2022.

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

Sections A.15.3 and A.15.4 of ATTACHMENT XI to the CRA require WLP 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 WLP and Tennessee Carriers, Inc., processed NEMT claims in compliance with Sections A.15.3 and A.15.4 of ATTACHMENT XI of the CRA for all months in calendar year 2022.

Prompt Pay Results for CHOICES Claims

Pursuant to Section A.2.22.4 of the CRA, WLP 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 CHOICES HCBS shall be processed and paid within fourteen (14) calendar days of receipt.

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

Prompt pay testing by TDCI determined that in September 2022 only 89% of nursing facility and CHOICES HCBS claims were processed within 14 calendar days of recent which is not in compliance with Section A.2.22.4 of the CRA.

WLP submitted to TDCI a corrective action plan for non-compliance with Section A.2.22.4 of the CRA for the month of September 2022. The corrective action plan was reviewed by TDCI and deemed sufficient.

Management Comments

Wellpoint management concurs with the findings and as mentioned above a Corrective Action Plan was submitted for the September of 2022 prompt pay failure.

Prompt Pay Results for ECF CHOICES HCBS Claims

Pursuant to Section A.2.22.4 of the CRA, WLP is required separately to comply with the following prompt pay claims processing requirements for Employment and Community First (ECF) CHOICES HCBS claims for services submitted electronically in a HIPAA-compliant format:

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

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

Prompt pay testing determined that ECF CHOICES HCBS claims were not processed in compliance with Section A.2.22.4 of the CRA for three months in calendar year 2022.

ECF CHOICES	Clean claims Within 14 days	All claims Within 21 days	Compliance
T.C.A. Requirement	90%	99.5%	
August 2022	87%	99.8%	**No**
September 2022	78%	81.5%	**No**
October 2022	78%	100.0%	**No**

WLP submitted to TDCI corrective action plans for each month of non-compliance with Section A.2.22.4 of the CRA. The corrective action plans were reviewed by TDCI and deemed sufficient.

Management Comments

Wellpoint management concurs with the above findings and Corrective Action Plans were completed for August, September and October non-compliant files.

The complete results of TDCI's prompt pay compliance testing can be found at https://www.tn.gov/commerce/tenncare-oversight/reports/prompt-pay-compliance-reports.html.

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

Several factors were considered in determining the extent of testing to be performed on WLP's claims processing system.

The following items were reviewed to determine the risk that WLP had not properly processed claims:

- Prior examination findings related to claims processing,
- Complaints or independent reviews on file with TDCI related to inaccurate claims processing,
- Results of prompt pay testing by TDCI,
- Results reported on the claims payment accuracy reports submitted to TDCI and the Division of TennCare,
- Review of the preparation of the claims payment accuracy reports,
- Review of the focused claims testing procedures and responses, and
- Review of internal controls related to claims processing.

C. Claims Payment Accuracy

1. Claims Payment Accuracy Reported by WLP

Section A.2.22.6 of the CRA requires that 97% of claims are processed or paid accurately upon initial submission. On a monthly basis, WLP submits claims payment accuracy reports to the Division of TennCare and TDCI based upon audits conducted by WLP. 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, thirty (30) claims associated with ECF CHOICES HCBS provided to ECF CHOICES members. The testing attributes to be utilized by WLP are defined in the CRA between WLP and the Division of TennCare. Additionally, subcontractors responsible for processing claims shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor.

WLP failed to achieve the contractual requirement of 97% claims payment accuracy during calendar year 2022 for the following months, claim types, and regions:

Month of Filing	Claim Type	Region	Percentage Reported
January 2022	TN- All Others	Middle	95.7%
March 2022	TN- All Others	East	94.8%
May 2022	ECF CHOICES HCBS	Middle	91.8%
July 2022	TN- All Others	Middle	95.6%
December 2022	Nursing Facility	Middle	95.0%

As each failure was reported, TDCI requested WLP to provide corrective action plans. When WLP identified system errors in the corrective action plans, TDCI followed up on the corrective action plans until the system issues were resolved. The Division of TennCare assessed WLP a total of $75,000 in liquidated damages during 2022 related to claims payment accuracy failures.

Management Comments

WellPoint management concurs with the findings for the January, March, May, July and August of 2022 and as mentioned above, corrective action plans were submitted for the non-compliant months.

2. Claims Payment Accuracy Reported by the NEMT Subcontractor

ATTACHMENT XI Section A.15.5 of the CRA requires WLP to pay 97% of Non-Emergency Medical Transportation (NEMT) claims accurately upon initial submission. Additionally, ATTACHMENT XI Section A.15.6 of the CRA requires an audit of NEMT claims that complies with the CRA's claims payment accuracy audit requirements. The NEMT subcontractor, Tennessee Carriers Inc., performed the audit and reported compliance with monthly claims payment accuracy requirements for all months in calendar year 2022.

3. Procedures to Review the Claims Payment Accuracy Reports

The review of the claims payment accuracy reports included an interview with responsible staff of WLP and the NEMT subcontractor, Tennessee Carriers Inc., to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy reports. The review included verification that the number of claims selected by WLP and the NEMT

subcontractor agreed to requirements set forth in Section A.2.22.6 and ATTACHMENT XI Sections A.15.5 and A.15.6 of the CRA. These interviews were followed by a review of the supporting documentation used to prepare the claims payment accuracy reports.

From claims payment accuracy reports prepared by WLP and the NEMT subcontractor for December 2022, TDCI judgmentally selected for verification twenty claims (10 Medical, 6 NEMT, and 4 vision) reported as accurately processed. TDCI tested these claims to the attributes required in Section A.2.22.6.4 of the CRA. No deficiencies were found.

D. Focused Claims Testing

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

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

For monthly focused claims testing by WLP during calendar year 2022, TDCI judgmentally selected 25 TennCare claims per Grand Region and 25 CoverKids claims from the data files submitted by WLP for prompt pay testing purposes. The focused areas for testing during calendar year 2022 included the following:

- Paid and denied medical claims
- Denied claims based on the Division of TennCare's COVID 19 Memorandums
- 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 WLP with the claims selected for testing and specified the attributes for WLP to self-test to determine if the claims were accurately processed. For the 1200 claims tested for the calendar year 2022, WLP reported at least one attribute error on 108 claims. It should be noted that a claim may fail more than one attribute. For the 108 claims, 190 attribute errors

were reported by WLP. The following table summarizes the focused claims testing errors reported by WLP for the calendar year 2022:

Attribute Tested	Errors Reported by WLP
Denial Reason Communicated to Provider Appropriate	107
Authorization Requirements Properly Considered	45
Modifier Codes Correctly Considered	12
Other Insurance Properly Considered	11
Payment Agrees to Provider Contracted Rate	7
Member Eligibility Correctly Considered	3
Correct Provider Is Associated to the Claim	3
Copayment Requirements Correctly Considered	1
Data Entry Is Verified With Hardcopy Claim	1
Total	190

For the 108 claims that contained attribute errors, WLP identified 32 that were the result of claims processing system errors and 76 that were the result of manual errors. For the system errors, WLP provided explanations which identified the error that occurred, identified the number of claims affected, and reported when all affected claims had been reprocessed. TDCI requested corrective action plans when additional explanation was deemed necessary. In subsequent monthly focused testing, TDCI selected similar claim types or claim denial reasons to monitor the resolution of system issues.

Management Comments

Wellpoint has reviewed the Draft Report and all files submitted for the audit. Management concurs with all findings and have met with our Audit team to discuss the audit attribution errors, education has been provided.

2. Deficiencies Noted by TDCI During Focused Claims Testing

TDCI noted claims processing deficiencies in addition to the errors identified by WLP during monthly focused testing. For each deficiency, TDCI requested WLP provide additional explanation including the resolution of system configuration issues and the reprocessing of the error claim and all other claims affected by the processing error. The following represents the significant additional items noted by TDCI during monthly focused testing for calendar year 2022:

a. For the January and February 2022 focused claims testing, WLP indicated there was a system configuration error which caused claims submitted by providers to incorrectly deny "ea4 Laterality Diagnosis Required." WLP determined this issue resulted in the reprocessing of 9,823 claims.

b. For the February, March, and April 2022 focused claims testing, WLP indicated a system configuration error caused claims submitted by a provider to incorrectly deny "G18 Disallow-not allowed under contract". WLP determined this issue required research of 19,001 claims to determine if reprocessing was required.

c. For December 2022, WLP indicated multiple manual errors due to incorrect processing instructions caused claims for multiple providers to incorrectly deny "g50-inappropriate/missing modifier for services" and/or "g81-submitted procedure is disallowed." WLP indicated 173 claims were affected by these errors.

d. For December 2022, WLP indicated a system configuration error caused claims for multiple providers to incorrectly deny "GDP-the submitted code is disallowed because the procedure is non-reimbursable" and "h61-the submitted procedure exceeded the maximum number of times allowed on a single date of service." WLP stated, "A claims edit was implemented without removing services that would allow more than 1 service per day." WLP indicated 767 claims were affected by this system error.

e. For December 2022, WLP indicated a system configuration error that caused claims for multiple providers to incorrectly deny "Y3Z – no authorization on file." WLP stated, "This was a system error where the incorrect provider ID was selected." WLP indicated 1,279 claims were affected by this system error.

<u>Management Comments</u>

Wellpoint management concurs with the TDCI audit findings. All errors above have been addressed and claims reprocessed.

3. Verification by TDCI of Focused Claims Testing Results

TDCI performed the procedures to verify the accuracy of WLP's reported focused claims testing results. TDCI judgmentally selected 55 claims for testing in which no errors were reported by WLP, and TDCI judgmentally selected 64 claims for testing in which WLP reported errors.

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

a. The following was noted for the 55 no error claims selected for reverification testing:

- For one TennCare claim, WLP incorrectly responded to the focused claims attribute "Correct provider is associated to the claim." The attribute was answered "Yes"; however, the attribute should have been answered "No" because WLP selected the incorrect provider ID. After field work, TDCI noted that the claim had been reprocessed and paid.

- For one TennCare claim, WLP incorrectly responded to the focus claims attribute "Other Insurance Properly Considered." The attribute was answered "Yes"; however, the attribute should have been answered "No" because of a manual error by the claims adjudicator where benefits were not properly coordinated with other insurance. As of January 23, 2024, TDCI noted that the claim has not been reprocessed.

- For one CoverKids claim, WLP incorrectly responded to the focus claims attribute "Other Insurance Properly Considered." The attribute was answered "Yes"; however, the attribute should have been answered "No" because of a manual error by the claims adjudicator where benefits were not properly coordinated with other insurance. After field work, TDCI noted that the claim had been reprocessed.

- For one NEMT claim, WLP incorrectly responded to the focus claims attribute "Other Insurance Properly Considered." The attribute was answered "Yes"; however, the attribute should have been answered "No" because of a manual error by the claims adjudicator where benefits were not properly coordinated with other insurance. As of January 23, 2024, TDCI noted that the claim has not been reprocessed.

WLP should develop controls to ensure focused testing attributes are responded to correctly and that claims identified as been processed incorrectly are promptly reprocessed.

<u>Management Comments</u>

Wellpoint management concurs with the findings above. We have provided additional education to the Audit team, stressing the importance of selecting the correct attribute.

b. The following was noted for the 64 error claims selected for reverification testing:

- For one claim reported as an error, WLP had not reprocessed and corrected the claim as of fieldwork during July 2023.

- For one claim reported as an error, WLP incorrectly responded to the focus claims attributes “Denial Reasons Communicated to Provider Appropriate” and "Other Insurance Properly Considered”. WLP reprocessed and paid the claim. After further review, WLP determined that the claim was originally processed correctly. WLP reprocessed and recovered the paid amount in April 2022.

- For two claims reported as errors, WLP did not pay the correct providers. The claims were reprocessed to pay the correct provider in January 2023. However, WLP failed to recoup the payment to the incorrect providers.

- For one CoverKids claim reported as an error, WLP failed to take a copayment. WLP reprocessed the claim in June 2022 to take a copayment. However, the claim was incorrectly reprocessed again in August 2022 to give the copayment back. As of July 2023, the claim had not been reprocessed and corrected.

Management Comments

WellPoint management concurs with the above findings. Our claims payment system, Facets has been reconfigured and the CoverKids copays are now taking the correct amounts.

E. Copayment Testing

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

TDCI requested from WLP a listing of the 100 TennCare and 100 CoverKids enrollees with the highest accumulated copayments for the period January 1, through December 31, 2022. From the listings, five (5) TennCare and three (3) CoverKids enrollees were judgmentally selected. The claims processed for the enrollees in calendar year 2022 were analyzed to determine if WLP had correctly applied copayment requirements of the CRA based upon the enrollees’ eligibility status.

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

- For one enrollee, WLP did not correctly apply a copayment for twenty-seven (27) office visits. WLP applied a $20 copayment; however, a $15 copayment should have been applied to the enrollee's claim based upon the enrollee’s eligibility status. Also, WLP did not apply a copayment for two (2) specialists visits. However, a $20 copayment should have been applied to the enrollee's claim based upon the enrollee’s eligibility status.

- For one enrollee, WLP did not apply a copayment for nine (9) Community Mental Health Center (CMHC) visits. However, a $15 copayment should have been applied to the enrollee's claim based upon the enrollee's eligibility status. Also, WLP did not correctly apply a copayment for two (2) CMHC visits. WLP applied a $20 copayment; however, a $15 copayment should have been applied to the enrollee's claim based upon the enrollee's eligibility status. Additionally, WLP did not correctly apply a copayment for two (2) office visits. WLP applied a $20 copayment; however, a $15 copayment should have been applied to the enrollee's claim based upon the enrollee's eligibility status.

- For one enrollee, WLP did not correctly apply a copayment for four (4) clinic visits. WLP applied a $5 copayment; however, no copayment should have been applied because a $5 copayment had already been applied for an office visit on the same date of service.

- For one enrollee, WLP did not apply a copayment for two (2) office visits. However, a $5 copayment should have been applied to the enrollee's claim based upon the enrollee's eligibility status.

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

- For one enrollee, WLP did not apply for a copayment for two (2) occupational therapy visits. However, a $15 copayment should have been applied to the enrollee's claim based upon the enrollee's eligibility status.

Management Comments

Wellpoint management concurs with the CoverKids copay errors. Facets has been corrected. We will not be reprocessing the claims and recouping the copays from the providers, as we do not believe the providers will be able to bill the members and receive the copays at this late date. Also, had the provider collected a copay from the member for a given date of service, when Wellpoint paid the claims without the copay, the member would have been refunded.

F. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether the remittance advice sent to providers accurately reflects 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 is to: (1) verify the actual payment of claims by WLP; 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 WLP to provide three cancelled checks or EFT documentation related to claims from the list of no error claims previously tested by TDCI. WLP provided the cancelled checks or the proof of EFT. The documents provided 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.

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 material liability exists for the unprocessed claims.

The pended and unpaid data files submitted to TDCI as of June 30, 2023, were reviewed for claims which were unprocessed and exceeded 60 days from the receipt date. The pended and unpaid data file of claims unprocessed by WLP, as well as subcontractors, indicate a total of 9,376 claims exceeding 60 days in process. Total first submission claims processed by WLP for June 2023 was 713,616. No material liability exists for claims over 60 days.

I. Mailroom and Claims Inventory Controls

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

TDCI did not perform a site visit of the mailroom operations of WLP and its subcontractors, EyeQuest and Tennessee Carriers, 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 reviewed to determine if incoming mail is properly inventoried and reconciled.
- Flowcharts documenting mailroom processes were reviewed.

No reportable deficiencies were noted by TDCI during the review of the mailroom and claim inventory controls for WLP, EyeQuest, and Tennessee Carriers, Inc.

VII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints Received by WLP

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

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

TDCI utilized the December 2022 provider appeal logs to verify the timeliness and accuracy of provider complaints. TDCI judgmentally selected twenty (20) provider complaints from the December 2022 WLP provider appeal log for review. The provider appeal log includes both initial requests for claims reconsideration and second level review requests, known as provider appeals. The selection criteria included provider complaints with processing lags of less than 30 days, between 30 and 60 days and greater than 60 days.

The following deficiencies were noted for the 17 reconsideration requests and 3 appeals selected:

- Five provider reconsideration requests tested were not resolved within 60 days of receipt. No written agreement was executed between the providers and WLP to allow additional time to resolve the reconsideration requests. Per Tenn. Code Ann section 56-32-126(b)(2)(A), " 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."

- For two of the provider reconsideration requests, the resolution date was incorrectly recorded on the log. The resolution date did not match the date on the resolution letter sent to the provider by WLP.

- For three reconsideration requests not resolved within 30 calendar days of receipt, WLP failed to inform the provider in an acknowledgement letter that a decision would be made within 60 calendar days of receipt. WLP policies and procedures and Tennessee Code Annotated require WLP to respond to reconsideration requests within 30 calendar days of the receipt of the request.

- For four of the provider reconsideration requests selected for testing, it was determined during TDCI’s review that WLP incorrectly denied the claims on

initial processing. Upon submission as a provider reconsideration request, WLP upheld its initial decision and continued to deny the claims. WLP's claim appeal procedures failed to properly determine the claims had been incorrectly denied.

- For one appeal, the resolution letter by WLP indicated the claim would be reprocessed; however, the claim had not been reprocessed as of TDCI's review on July 17, 2023.

Management Comments

Wellpoint management concurs with the findings for the appeals and reconsiderations. The Reconsideration Manager has provided additional training to his team and has addressed the specific errors identified with the associate who made the error.

B. Provider Complaints Received by TDCI

TDCI offers providers a complaint process for disputes with TennCare MCOs. Complaints may involve claims payment accuracy and timeliness, credentialing procedures, inability to contact or obtain assistance from the MCO, miscommunication or confusion around MCO policy and procedures, etc. When a provider complaint is received, TDCI forwards the complaint to the MCO for investigation. The MCO is required to respond in writing within 30 calendar 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, 2022, TDCI received and processed 236 provider complaints against WLP. The responses by WLP to providers were categorized by TDCI in the following manner:

Previous denial or underpayment reversed in favor of the provider	143
Previous denial or payment upheld	66
Previous denial or underpayment partially reversed in favor of the provider	9
Ineligible or duplicate complaint	2
Resolved	10
Withdrawn	3
Question by provider answered	3
Total	236

TDCI judgmentally selected 29 provider complaints for review. Each provider complaint selected represented one claim. The issues raised by the providers were analyzed and questions were posed to WLP for response. Emphasis was placed on discovering deficiencies in the WLP's claims processing system or provider complaint procedures.

The following deficiencies were noted during the review of WLP's provider complaint review processes:

- Sixteen claims were denied incorrectly upon initial submission by the provider. The providers submitted the claims for reconsideration, however WLP failed to overturn the incorrect denials.

- Three claims were submitted as reconsideration requests to WLP. The plan failed to process the request within 60 days as required by Tenn. Code Ann. § 56-32-126(b)(2)(A). The significant delay in the processing of reconsideration request resulted in the provider having to submit provider complaints to TDCI.

- One claim was denied with the explanation reason, "dismissed due to the claims still pending a final disposition." The denial reason is not appropriate since it does not communicate a final resolution of the claim or why the claim continues to be denied. The inappropriate denial reason resulted in the provider having to submit a provider complaint to TDCI.

- One claim was incorrectly denied upon initial submission because WLP did not associate the service to a properly received prior authorization. The reconsideration request submitted by the provider was upheld because the reconsideration was not submitted timely per WLP guidelines. After submission to TDCI as a provider complaint, WLP overturned the denial for good cause.

Management Comment

Wellpoint agrees with the State Complaint findings. With each State Complaint the error found is discussed with the Manager of the department who made the error. If warranted, additional associate education is given.

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, 2022, 26 independent reviews were initiated by providers against WLP. The following is a summary of the reviewer decisions:

Reviewer decision in favor of WLP	9
Reviewer decision in favor of the provider	3
Reviewer decision partially for the provider and WLP	4
Ineligible for independent review process	5
Referred to the Division of TennCare	1
Settled for the provider	4
Total	26

TDCI judgmentally selected five independent reviews for testing. The issues raised by the providers were analyzed and questions were posed to WLP for response. Emphasis was placed on discovering deficiencies in the WLP's claims processing system or provider complaint and appeal procedures. For the 5 independent reviews selected for testing, no reportable deficiencies were noted.

D. Provider Manual

The provider manual outlines written guidelines to providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim. WLP routinely submits updates to the provider manual to TDCI for prior approval. An update of the provider manual was approved by TDCI on March 13, 2023.

E. Provider Agreements

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

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

A total of 55 executed provider agreements were requested from the no error claims selected for focused testing in section VI.D. of this examination report. The provider agreements selected included five executed by the transportation subcontractor, Tennessee Carriers, Inc. and five executed by the vision subcontractor, EyeQuest.

Of the 55 provider agreements tested, the following deficiencies were noted:

- For three WLP provider agreements, the executed agreements did not utilize the provider agreement templates most recently approved by TDCI.

- For one WLP provider agreement, an amendment was executed but was not submitted to TDCI for prior approval.

- For two WLP provider agreements, rate sheets were executed but were not submitted to TDCI for prior approval.

- For one WLP provider agreement, the agreement had been correctly submitted to TDCI for prior approval; however, WLP executed the agreement before TDCI issued an approval.

- For two EyeQuest provider agreements, the executed agreements had not been submitted to TDCI for prior approval. Additionally, during the claims processing operations review for EyeQuest, TDCI noted an executed provider agreement was never submitted to TDCI for prior approval.

- For one Tennessee Carriers provider agreement, the updated fee schedule was not submitted to TDCI for prior approval.

Management Comments

Wellpoint management concurs with the findings for Provider Agreements.

F. Provider Payments

Capitation payments made to providers during 2022 were tested to determine if WLP 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. No deficiencies were noted.

G. Subcontracts

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

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

H. Subcontractor Monitoring

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

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

I. Non-discrimination

Section A.2.28.2 of the CRA requires WLP to demonstrate compliance with the applicable state and federal civil rights laws, guidance, and policies. including Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, the Age of Discrimination Act of 1975 and the Church Amendments (42 U.S.C. 300a-7), Section 245 of the Public Health Service Act (42 U.S.C. 238n.), and the Weldon Amendment (Consolidated Appropriations Act 2008, Public Law 110-161, Div. G, Sec. 508(d)m 121 Stat. 1844,

2209). Based on discussions with various WLP staff and a review of policies and related supporting documentation, WLP was in compliance with the reporting requirements of Section A.2.28.2 of the CRA.

J. Internal Audit Function

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

The Internal Audit Department of WLP's parent company, Elevance Health, Inc., performs engagements of WLP specific to its TennCare operations. Additionally, the Internal Audit Department performs monthly claims payment accuracy testing in compliance with Section A.2.21.10 CRA. 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 requires 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 to register with the commissioner. WLP 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 WLP received in 2023 for the calendar year 2022.

L. Health Insurance Portability and Accountability Act (HIPAA)

Section A.2.27 of the CRA requires WLP to comply with requirements of the Health Insurance Portability and Accountability Act of 1996 and Health Information Technology for Economic and Clinical Health (HITECH) under the American Recovery and Reinvestment Act of 2009, including but not limited to, the transactions and code set, privacy, security, and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data partner situations required under the regulations.

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

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

M. Conflict of Interest

Section E.28 of the CRA warrants that no part of the amount provided by TennCare shall be paid directly, indirectly or through a parent organization, subsidiary or an affiliate organization to any state of federal officer or employee of the State of Tennessee or any immediate family member of a state of federal 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 WLP in connection with any work contemplated or performed relative to the CRA unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

Conflict of interest requirements of the CRA were expanded to require an annual filing certifying that the MCO is in compliance with all state and federal laws relating to conflicts of interest and lobbying.

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

The MCO is responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and for including the substance of the CRA conflict of interest clauses in all subcontracts, provider agreements and any and all agreements that result from the CRA.

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

- The most recently approved provider agreement templates contain the conflict of interest language of the CRA.
- The organizational structure of WLP includes a compliance officer who reports to the President/CEO.
- WLP 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.

Failure to comply with the provisions required by the CRA shall result in WLP paying liquidated damages in accordance with section E.29 of the CRA.

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

N. Episodes of Care Testing

In 2013, the State of Tennessee launched Tennessee's Health Care Innovation Initiative with the goal to move from paying for volume to paying for value with health care providers being rewarded for desirable outcomes: the high quality and efficient treatment of medical conditions and the maintenance of health over time.

One strategy, Episode-Based Payments, focuses on the health care delivered in association with acute healthcare events such as a surgical procedure or an inpatient hospitalization. Retrospective episode-based payment rewards providers who successfully achieve high quality and efficient outcomes during an "episode of care," a clinical situation with start and end points that may involve multiple independent providers. This approach rewards high-quality care, promotes the use of clinical pathways and evidence-based guidelines, encourages coordination, and reduces ineffective and/or inappropriate care. For each episode type, a principal accountable provider (also referred to as a PAP or Quarterback) is determined based upon the provider deemed to be in the best position to influence the quality and cost of care for the patient. The design of each episode is aligned for all MCOs. For every enrollee affected, a non-risk adjusted episode spend amount is determined based upon the total cost of claims from all providers that meet design requirements. Risk adjustment is the mechanism that the episode-based models use to achieve a comparison between PAPs. The final risk adjustment methodology decisions are made at the discretion of the MCO after analyzing the data. Each MCO runs its own risk adjustment model because there are variations in the population covered and significant risk factors may vary across MCOs. Episode of care rewards and penalties are in addition to the normal claims payment arrangements between an MCO and a provider and do not have an impact on those arrangements. The MCO sends interim quarterly and final annual reports to each PAP to inform them about their performance in the episode-based payment model. The final provider report will notify the PAP of the total average episode cost (risk adjusted) compared to the acceptable or commendable cost thresholds. PAPs that achieve the commendable cost threshold are rewarded for their high performance in the previous year. PAPs that exceed the acceptable cost threshold are assessed a financial penalty for a share of the amount of costs that were over and above all their peers. A more detailed explanation of episode of care initiative can be found at https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html.

Beginning with the provider reports issued in August 2016, TDCI, at the request of the Division of TennCare, began quarterly testing the accuracy of the reports prepared by the MCOs. From listings of all enrollee episodes for each quarter, TDCI randomly selected a sample of 25 enrollee episodes included in the PAP's average cost calculations and requested from the plan supporting provider reports, claims data files, and risk marker supporting files. The provider reports were vouched to supporting claims in the claims data files. Utilizing the design dimensions for each episode-based model, TDCI applied inclusion and exclusion criteria to the claims data files including, but not limited to, the following:

- Age parameters
- Episode period requirements
- Diagnosis codes
- Procedure diagnosis codes
- Procedure codes
- Revenue codes
- Bill types
- Place of service types
- Modifier codes.

The risk marker supporting files were reviewed to determine if the MCO's risk adjustment model was applied consistently for each episode. Other tests included, but were not limited to, verification of claims data files with claims reported to the Division of TennCare as encounter data. Also, for each quarter, TDCI selects for testing enrollee episodes excluded from the PAPs average cost calculations.

TDCI selected for testing a total of 100 enrollee included episodes from final and interim reports issued by WLP from February 2022 through November 2022. Also, TDCI selected for testing 100 enrollee episodes excluded from the PAP's average cost calculations. The following table reports the results of testing by episode of care from final and interim reports issued by WLP from February 2022 through November 2022.

Results of Episodes of Care Testing

Population	Attribute Tested	Errors noted
Episodes included in the PAPs' average cost calculations	Was the episode a valid and properly included episode (i.e. not an episode that should have been classified as an excluded episode)?	0
	Were the costs of all applicable claims included in the total of non-adjusted costs for the episode?	0
	Were applicable risk markers properly identified according to the risk adjustment model adopted by the MCO?	0
	Was the risk adjusted cost of the episode properly calculated according to the risk adjustment model adopted by the MCO?	0
Episodes excluded from the PAPs' average cost calculations	Was the exclusion reason noted in provider reports supported by claims information?	0

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

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, 2020:

A. Financial Deficiencies

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

B. Claims Processing Deficiencies

1. Prompt pay testing by TDCI determined that CHOICES claims were not processed in compliance with Section A.2.22.4 of the CRA for the month of February 2020.

2. Prompt pay testing determined that ECF CHOICES HCBS claims were not processed in compliance with Section A.2.22.4 of the CRA for February, March, April, May, October, November, and December of 2020.

3. WLP failed to achieve claims payment accuracy requirements of 97% per Section A.2.22.6 of the CRA for:

   - CHOICES HCBS in January 2020 for East, Middle, and West Regions.
   - ECF CHOICES HCBS in March 2020 for the Middle Region.
   - Nursing Facilities in July 2020 for the West Region and in August 2020 for East, Middle, and West Regions.

4. During the review of WLP's December 2020 claims payment accuracy report, TDCI noted that one of the fifteen claims selected for testing was paid in error. The claim should have been paid by the member's other insurance before the claim was paid by TennCare.

5. The CRA requires WLP to self-test the accuracy of claims processing based on claims selected by TDCI on a monthly basis. For the 900 claims tested for calendar year 2020, WLP reported at least one attribute error on 103 claims during focused claims testing.

6. During the review of focused claims testing results, TDCI noted seven additional claims processing deficiencies that resulted in the reprocessing of 21,313 claims with billed charges of $3,183,850. Details of the additional deficiencies are described in this report.

7. The following deficiencies were noted by TDCI during the reverification testing of 45 claims in which WLP reported no errors during their focused claims testing results:

   - For one claim selected by TDCI for reverification, WLP incorrectly denied claim lines with the explanation code "Primary Carrier denied the procedure code/bill type is inconsistent with the place of service."

   - For one claim selected by TDCI for reverification, WLP incorrectly denied claims lines with the explanation code “Deny preauth not obtained."

8. The following deficiency was noted by TDCI during the reverification testing of 36 claims in which WLP reported errors during their focused claims testing results. One error claim was not properly reprocessed by WLP. As a result, WLP incorrectly paid for 2 home delivered meals on the same date of service.

9. For two of the five enrollees selected for copayment testing, WLP failed to properly apply copay requirements based on the enrollee’s eligibility status.

Findings 2,3,4,5,6,7,8, and 9 have been repeated in the current examination.

C. Compliance Deficiencies

1. For the test month of December 2020, the following deficiencies were noted in review of WLP’s claim processing provider complaint log:

   - Two of the 15 complaints selected were not resolved within 30 days of receipt and WLP failed to inform the provider that a decision would be made within 60 days of receipt.

   - Eight of the 15 provider complaints selected were not resolved within 60 days. No written agreement with the provider and WLP was executed to allow for additional time to resolve the complaint.

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

3. For one of the provider agreements selected for testing, WLP submitted and TDCI approved an agreement specific to two providers. After the initial approval by TDCI, the provider agreement was altered to include an additional provider before execution. The amended agreement was not resubmitted to TDCI for approval.

4. WLP's subcontractors, Tennessee Carriers, Inc., and EyeQuest, failed to obtain written approval in advance from the Division of TennCare for customer service call centers subcontracts. Additionally, the subcontracts were not submitted to TDCI for approval.

Findings 1,2, and 3 have been repeated in the current examination.