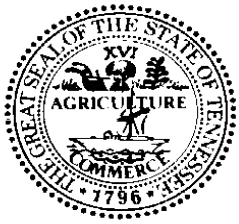

STATE OF TENNESSEE

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

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

CHATTANOOGA, TENNESSEE

FOR THE PERIOD JANUARY 1, 2011
THROUGH DECEMBER 31, 2011

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VIA: Gregg Hawkins, CPA, Assistant Director
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DATE: March 27, 2013

The Market Conduct Examination and Financial and Compliance Examination of Volunteer State Health Plan, Inc., Chattanooga, Tennessee was completed on July 13, 2012. The report of this examination is herein respectfully submitted.

I. FOREWORD

On January 12, 2012, 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 market conduct, limited scope financial statement, and compliance examination. Fieldwork began on May 7, 2012 and ended on May 18, 2012. All document requests were provided by July 13, 2012.

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 by VSHP. This report also reflects the results of a compliance examination of VSHP's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of VSHP was conducted jointly by TDCI and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 2.25 of the CRAs for the East and West Tennessee Grand Regions and Section 2.15 of the Agreement for the Administration of TennCare Select (AATS) between the State of Tennessee and VSHP, Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) § 56-32-115 and § 56-32-132.

VSHP is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of VSHP. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.

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

31, 2011, and the Medical Fund Target Report and Medical Loss Ratio Reports filed by VSHP as of December 31, 2011.

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

Fieldwork was performed using records provided by VSHP before and during the onsite examination from May 7, 2012 through May 18, 2012 and additional documents provided after the onsite examination through July 13, 2012.

C. Purpose and Objective

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

The objectives of the examination were to:

- Determine whether VSHP met certain contractual obligations under the CRAs 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 properly adjudicated claims from service providers and made payments to providers in a timely manner;
- Determine whether VSHP implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and
- Determine whether VSHP corrected deficiencies outlined in prior TDCI examinations of VSHP.

III. PROFILE

A. Administrative Organization

VSHP is a wholly owned subsidiary of Southern Diversified Business Services, Inc. (SDBS) which is a wholly owned subsidiary of Blue Cross Blue Shield of Tennessee,

Inc. (BCBST). BCBST performs certain administrative functions of VSHP through an administrative services agreement between VSHP and BCBST.

The officers and board of directors for VSHP at December 31, 2011, were as follows:

Officers for VSHP

Scott Christian Pierce, President and CEO
Sheila Dean Clemons, Secretary
Katherine Anne Laurance, Assistant Secretary
Daniel Paul Timblin, Treasurer
Alaine Marie Zachary, Assistant Treasurer
Steven Edward Kerr, Vice President of Finance
David Matthew Moroney, MD, Vice President and Chief Medical Officer
Amber Jeanine Cambron, Chief Operating Officer
James Howard Srite, Actuary

Board of Directors or Trustees for VSHP

Vicky Brown Gregg, Chairman
John Francis Giblin
William Morgan Gracey

B. Brief Overview

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

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

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

eligibility classification.

As of December 31, 2011, TennCare Select had approximately 88,000 TennCare members for all Grand Regions and BlueCare had approximately 210,000 TennCare members for the East Tennessee Grand Region and approximately 189,000 for the West Tennessee Grand Region.

Effective March 1, 2010, the AATS and effective August 1, 2010, the CRAs for the East and West Tennessee Grand Regions were amended for the implementation of the CHOICES program. CHOICES is TennCare's program for long-term services and supports (LTSS). LTSS includes 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) 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, 2011, VSHP had approximately 5,400 CHOICES enrollees in the East Tennessee Grand Region, 4,000 CHOICES enrollees in the West Tennessee Grand Region, and 2 CHOICES enrollees in TennCare Select.

C. Claims Processing Not Performed by VSHP

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

- Dental
- Pharmacy

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

- Non-emergency Medical Transportation (NEMT) – Southeastrans, Inc. (SET)
- Durable Medical Equipment – CareCentrix

During the period under examination, VSHP subcontracted with Value Options of Tennessee, Inc. (VOTN) to arrange for the delivery of behavioral health services through a network of providers contracted with VOTN.

IV. PREVIOUS EXAMINATION FINDINGS

The previous examination findings are provided for informational purposes. The following were claims processing and compliance deficiencies cited in the examination by TDCI for the period January 1, 2008 through December 31, 2008:

A. Financial Deficiencies

1. The Notes to the Financial Statements and the Management Discussion and Analysis to Annual Statement failed to disclosure certain transactions between affiliates related to three administrative service agreements. Additionally, these agreements were not submitted to TDCI for prior approval pursuant to Tennessee Code Annotated §§56-11-106 and 56-32-103(c)(1).

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

Neither of these financial deficiencies are repeated in the current report.

B. Claims Processing Deficiencies

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

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

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

4. For preparation of claims payment accuracy reports, VSHP did not maintain for audit and verification purposes the results of testing for a contractually required testing attribute.

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

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

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

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

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

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

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

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

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

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

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

Findings 1, 2 and 7 have been repeated in the current report.

C. Compliance Deficiencies

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

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

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

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

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

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

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

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

Findings similar to 3, 5 and 6 have been repeated in the current report.

V. SUMMARY OF CURRENT FINDINGS

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

A. Financial Deficiencies

1. No amounts were reported as marketing expenses on Report 2A for TennCare Select. However, marketing expenses were incurred by VSHP for TennCare approved health education and outreach activities as well as general marketing expenses allocated from BCBST. These expenses were incorrectly reported on Report 2A on Line 5604 entitled "Legal Fees, Books, Board and Assoc. fees, Collection fees, etc." instead of Line 52 "Marketing".

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

2. No amounts were reported as marketing expenses on Report 2A for East and West Tennessee CRAs. However, marketing expenses were incurred by VSHP for TennCare approved health education and outreach activities as well as general marketing expenses allocated from BCBST. These expenses were incorrectly reported on Report 2A on Line 5604 entitled "Legal Fees, Books, Board and Assoc. fees, Collection fees, etc." instead of Line 52 "Marketing".

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

B. Claims Processing Deficiencies

1. Based on an analysis of the total of all claims processed by VSHP and subcontractors for all contracts with the TennCare Bureau, VSHP was not in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for the month of October 2011. The plan did not maintain compliance with prompt pay standards for 12 months after the October 2011 failure, failing to meet prompt pay standards in January 2012. TDCI assessed against VSHP an administrative penalty pursuant to the authority of Tenn. Code Ann. § 56-32-120 in the amount of $10,000.

   (See Section VII.A. of this report)

2. Based on an analysis of claims processed under each contract with the TennCare Bureau, VSHP was not in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for the month of October 2011 in the East Tennessee Grand Region, the West Tennessee Grand Region and for TennCare Select operations.

   (See Section VII.A. of this report)

3. VSHP's NEMT claims processing subcontractor was not in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for the month of February 2011 in the East Tennessee Grand Region.

   (See Section VII.A. of this report)

4. VSHP's DME claims processing subcontractor was not in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for the period March 1, 2011 through September 30, 2011 in East Tennessee Grand Region, West Tennessee Grand Region and for TennCare Select operations during the calendar year ending December 31, 2011.

   (See Section VII.A. of this report)

5. VSHP's NEMT claims processing subcontractor was not in compliance with the contractually required 97% claims payment accuracy standard for the third quarter 2011 for East and West Tennessee Grand Regions and for the second and third quarters 2011 for TennCare Select operations.

   (See Section VII.C. of this report)

6. VSHP's NEMT claims processing subcontractor incorrectly excluded adjusted claims from prompt pay data files submitted to TDCI for the purpose of determining compliance with prompt pay standards in Tenn. Code Ann. § 56-32-126(b)(1).

   (See Section VII.D. of this report)

7. For seven of the 152 claims processed by VSHP that were selected for testing, the denial explanation reason code transmitted to the providers did not specify the reason for denial.

   (See Section VII.F. of this report)

8. For one of the 152 claims processed by VSHP that were selected for testing, the claim was denied with the explanation of "not a valid code for reimbursement." The procedure code was billed by the provider with an invalid modifier for reimbursement. The claim should have been denied explaining that the modifier billed with the procedure code was invalid for reimbursement.

   (See Section VII.F. of this report)

9. For one of the 152 claim processed by VSHP that were selected for testing , one service line on the claim was incorrectly denied with the explanation exceeds timely filing limits. The claim was appropriately filed within the timely filing limit of 120 days.
   (See Section VII.F. of this report)

10. For one of the 152 claims processed by VSHP that were selected for testing, a Home Community Based Service was denied because the number of services provided exceeded the amount prior authorized by VSHP's care management system. The claim was submitted by the provider through an electronic verification system (EVV) operated through a VSHP subcontractor. The EVV system failed to

properly enforce the authorization limits as determined by VSHP's care management system. Without the enforcement of authorization limits, providers are allowed to bill for services contrary to the amount of services specified in the enrollee's plan of care.

(See Section VII.F. of this report)

11. VSHP's DME claims processing subcontractor states on remittance advices that all provider claims must be received within 45 days. The statement is contrary to timely filing limits of 120 days per the CRAs for East and West Tennessee and the AATS.

(See Section VII.I. of this report)

C. Compliance Deficiencies

1. For one transportation provider agreement, the executed agreement did not agree with the version previously approved by TDCI. Per the Agreement for the Administration of TennCare Select and Section 2.12.2 of the CRA for the East and West Tennessee Grand Regions, all template provider agreements and revisions thereto must be approved in advance by TDCI.

(See Section VIII.E. of this report)

2. VSHP experienced difficulties in implementing the requirements of the CHOICES program in the East and West Tennessee Grand Regions. Audits by the TennCare Bureau resulted in the assessment of liquidated damages of $13,050,000 for the CHOICES program. The audits noted VSHP's failure to document contact with new members and the establishment of referrals.

(See Section VIII.M. of this report)

3. As described above, TDCI noted in claims testing an issue related to the CHOICES Program. The EVV system failed to properly enforce the authorization limits as determined by VSHP's care management system. Without the enforcement of authorization limits, providers are allowed to bill for services contrary to the amount of services specified in the enrollee's plan of care

(See Section VIII.M. of this report)

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

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

quarterly financial statements in accordance with NAIC guidelines with the Tennessee Department of Commerce and Insurance. The department uses the information filed on these reports to determine if VSHP meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash, if necessary, to pay outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

At December 31, 2011, VSHP reported $393,928,502 in admitted assets, $218,893,393 in liabilities and $175,035,109 in capital and surplus on the Annual Statement for the Year Ended December 31, 2011 submitted March 1, 2012. VSHP reported total net income of $73,499,110 on the statement of revenue and expenses for the period January 1, 2011 to December 31, 2011. The 2011 Annual Statement and other financial reports submitted by VSHP can be found at http://www.tn.gov/commerce/tenncare/mcoreports.shtml.

1. Capital and Surplus

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

Tenn. Code Ann. § 56-32-112(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions of the federal Social Security Act (title XIX), and regulations promulgated pursuant thereto, or pursuant to any other federal law as adopted by amendment to the required title XIX state plan..." Based on this definition, all TennCare payments made to an HMO licensed in Tennessee for the provision of health care 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 2.21.6.1 of the CRAs for East and West Tennessee and the AATS require VSHP to establish and maintain the minimum net worth requirements required by TDCI, including but not limited to Tenn. Code Ann. § 56-32-112.

2011 Statutory Net Worth Calculation

VSHP's revenues for 2011 totaled $2,072,161,833 ($1,695,982,644 reported risk premium revenue for BlueCare East and BlueCare West plans and $376,179,189 non-risk payments made by the state pursuant to the federal

waiver for Title XIX); therefore, VSHP's current statutory net worth requirement is $34,832,427 ($150,000,000 x 4% + ($2,072,161,833-150,000,000) x 1.5%). VSHP's reported net worth at December 31, 2011 was $140,202,682 in excess of the minimum required.

TennCare Premium Revenue for the Examination Period

The following is a summary of VSHP's premium revenue from TennCare operations as defined by Tenn. Code Ann. § 56-32-112(a)(2) for the examination period January 1 through December 31, 2011:

East and West Tennessee Grand Regions		
Total Tennessee Capitation Payments for the period January 1 through December 31, 2011	$1,695,914,932	
Quality Incentive Payments for the period January 1 through December 31, 2011	67,712	$1,695,982,644
TennCare Select		
Administrative fee payments from TennCare for the period January 1 through December 31, 2011	$ 9,300,681	
Reimbursement for medical payments from TennCare for the period January 1 through December 31, 2011	346,676,551	
Reimbursement for premium tax payments from TennCare for the period January 1 through December 31, 2011	20,201,957	$376,179,189

Total premiums for TennCare operations for the period January 1 through December 31, 2011	$2,072,161,833

2. Restricted Deposit

Tenn. Code Ann. § 56-32-112(b) requires HMOs to establish a restricted deposit and defines the calculation of the deposit based upon annual premium revenue. However, Section 2.21.5.2 of the AATS and Section 2.21.6.4 of the CRAs for East and West Tennessee require MCOs to have on deposit an amount equal to the calculated minimum net worth requirement per Section 2.21.6.1 of the CRAs for East and West Tennessee. VSHP's restricted deposit requirement for calendar year 2012 was calculated based on estimated total TennCare premiums for East and West Tennessee Grand Regions and cash payments for TennCare Select. Total TennCare premiums of $2,072,161,832 were utilized resulting in a restricted deposit requirement of $34,832,427. On March 30, 2012, VSHP submitted to TDCI a safekeeping receipt which increased VSHP's total restricted deposit to $34,850,000.

3. Claims Payable

As of December 31, 2011, VSHP reported $159,627,541 claims unpaid, $8,014,422 unpaid claims adjustment expense, and $850,917 accrued medical incentive pool and bonus amounts on the Annual Statement for the Year Ended December 31, 2011. These amounts were certified by a separate statement of actuarial opinion.

The claims unpaid amount represents an estimate for the East and West Tennessee Grand Region at-risk operations for TennCare for the period ending December 31, 2011. Based on a review of the payments after December 31, 2011, the liability was sufficient to meet the actual unpaid claims.

The unpaid claims adjustment expense represents a liability of administrative costs to process claims that have been incurred but not received or processed as of December 31, 2011.

The accrued medical incentive pool and bonus amount represents an estimate for additional payments to provider that achieve contractual benchmarks.

4. Management Agreement and Administrative Expense Allocations

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

allocation method consistent with NAIC Statement of Statutory Accounting Principles (SSAP) No. 70.

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

The allocation methodologies utilized by VSHP were reviewed by TDCI. VSHP performs an analysis of allocated expenses on a monthly basis. The following excerpts were provided by VSHP to explain the allocation methodology.

- The first step in the allocations process is to 'charge back' certain expenses for benefits, employee technology, and facility costs to all departments with staffing that drive these costs. Most of these 'chargebacks' are based on either headcount or salary expense depending upon the nature of the expense.

- The second step in the allocations process is to allocate the fully loaded expense for each department defined corporately as a 'direct' department based on their rollup in the organization. In general, these are departments responsible for the operational activities of the company. An effort is made to group departments based on similar activities. Departments within each grouping are then pooled and allocated to line of business (LOBs) using a common methodology based on the most appropriate driver of expense. The methodology employed is one expected to yield the most accurate results, and may be based on pertinent factors or ratios for expenses shared by multiple LOBs.

- The next step in the allocations process is to allocate the fully loaded expenses for each department defined corporately as a 'support' department based on their rollup in the organization. In general, these departments include; Finance, Information Systems, Human Resources, Legal, Compliance, Public Relations, and Corporate Services. While there are some exceptions, in general these expenses are allocated to lines of business using the 'corporate ratio' method. The 'corporate ratio method' in essence determines a ratio of direct expense for each LOB to the total direct expense for all LOBs.

TDCI notes that there are over 400 cost centers that include expenses paid by BCBST on behalf of VSHP or for services performed by BCBST that are allocated to VSHP. Expenses that can be specifically identified to VSHP are

charged directly to the VSHP. Where specific identification is not possible, pertinent factors or ratios were utilized to allocate shared expenses.

The allocation schedules provided by VSHP were compared to the general ledger and the amounts reported on the Underwriting and Investment Exhibit Part 3 – Analysis of Expenses on the NAIC Annual Statement for the year ended December 31, 2011. TDCI requested additional support for Marketing and Advertising of approximately $1,779,000 which consists of $821,000 in direct expenses and $958,000 in allocated expenses. Direct expenses were confirmed as costs associated with TennCare approved marketing expenses such as health education and outreach. Allocated expenses consist of a percentage of the general marketing and advertising costs incurred by BCBST.

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 Section 2.10.h.2 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.

The following deficiency was noted during the review of Report 2A s for the TennCare Select program for the year ended December 31, 2011:

As stated above, marketing expenses were incurred by VSHP for TennCare approved health education and outreach activities as well as general marketing expenses allocated from BCBST. These expenses were incorrectly reported on Report 2A on Line 5604 entitled "Legal Fees, Books, Board and Assoc. fees, Collection fees, etc." instead of Line 52 "Marketing".

Management Comments

Management concurs. Not including expenses on the Marketing line 52 of Report 2A was an oversight and will be corrected going forward in subsequent filings.

2. TennCare Operating Statement of the At-Risk Operations of the East and West Tennessee Grand Regions

Section 2.30.15.3.4 of the CRAs for East and West Tennessee Grand Regions 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.

The following deficiency was noted during the review of the Report 2A for the TennCare Select program for the year ended December 31, 2011:

As stated above, marketing expenses were incurred by VSHP for TennCare approved health education and outreach activities as well as general marketing expenses allocated from BCBST. These expenses were incorrectly reported on Report 2A on Line 5604 entitled "Legal Fees, Books, Board and Assoc. fees, Collection fees, etc." instead of Line 52 "Marketing".

Management Comments

Management concurs. Not including expenses on the Marketing line 52 of Report 2A was an oversight and will be corrected going forward in subsequent filings.

C. Medical Fund Target Report

Section 2.10.12 of the AATS requires that VSHP submit a Medical Fund Target Report (MFT) on a monthly basis. The 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 MFT amounts reported.

D. Medical Loss Ratio Report

Section 2.30.15.2.1 of the CRAs for the East and West Tennessee Grand Regions states in part:

> The CONTRACTOR shall submit a *Medical Loss Ratio Report (MLR)* 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 must reconcile to NAIC filings including the supplemental TennCare income statement.

VSHP BlueCare East had a MLR of 85.09% and VSHP BlueCare West had a MLR of 84.54% for the period ending December 31, 2011.

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

E. Schedule of Examination Adjustments to Capital and Surplus

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

VII. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames set forth in Tenn. Code Ann. § 56-32-126(b)(1) and Section 2.22.4 of the CRAs for the East and West Tennessee Grand

Regions and Section 2.1.i. 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. The data files contain all claims processed in the month being tested for compliance with prompt pay requirements 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 12 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, the NEMT subcontractor, and the DME subcontractor.

VSHP All TennCare Operations	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2011	93%	99.8%	**Yes**
February 2011	97%	99.9%	**Yes**
March 2011	98%	99.9%	**Yes**
April 2011	99%	99.9%	**Yes**
May 2011	99%	99.9%	**Yes**
June 2011	99%	100.0%	**Yes**
July 2011	99%	99.9%	**Yes**
August 2011	98%	99.9%	**Yes**
September 2011	94%	99.9%	**Yes**
October 2011	89%	96.1%	**NO**
November 2011	95%	99.9%	**Yes**
December 2011	94%	99.9%	**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 2011 with the exception of October 2011. VSHP responded with a corrective action plan to TDCI's prompt pay results letter. As stated above, VSHP had to maintain compliance for twelve months after the October 2011 failure to avoid assessment of an administrative penalty. However, VSHP was found to be out of compliance again in January 2012 when it processed only 89% of clean claims within 30 days and 96.1% of all claims within 60 days. TDCI thus assessed an administrative penalty pursuant to the authority of Tenn. Code Ann. § 56-32-120 in the amount of $10,000.

Management Comments

Management concurs. This issue was the result of VSHP's durable medical equipment (DME) vendor, CareCentrix, failure to meet prompt pay requirements for DME during the months in question and directly resulting in BlueCare East, BlueCare West, and TennCare Select being out of compliance for those months. A corrective action plan was submitted to the Tennessee Department of Commerce and Insurance. Also, VSHP has now re-assumed the responsibility for processing DME claims effective November 1, 2012

Prompt Pay Results by Region and TennCare Select Contracts

The following tables represent the results of prompt pay testing by the East and West Grand Regions and TennCare Select for all claims processed by VSHP including claims processed by the NEMT subcontractor and the DME subcontractor for the period January 1 through December 31, 2011.

VSHP East Contract	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2011	93%	99.9%	**Yes**
February 2011	97%	99.9%	**Yes**
March 2011	98%	99.9%	**Yes**
April 2011	99%	99.9%	**Yes**
May 2011	99%	100.0%	**Yes**
June 2011	99%	100.0%	**Yes**
July 2011	99%	99.9%	**Yes**
August 2011	98%	100.0%	**Yes**
September 2011	94%	99.9%	**Yes**
October 2011	88%	95.5%	**NO**
November 2011	95%	100.0%	**Yes**
December 2011	93%	99.9%	**Yes**

VSHP West Contract	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2011	93%	99.9%	**Yes**
February 2011	98%	99.9%	**Yes**
March 2011	99%	99.9%	**Yes**
April 2011	99%	99.9%	**Yes**
May 2011	99%	99.9%	**Yes**
June 2011	99%	100.0%	**Yes**
July 2011	99%	99.9%	**Yes**
August 2011	98%	99.9%	**Yes**
September 2011	94%	99.9%	**Yes**
October 2011	90%	97.1%	**NO**
November 2011	96%	100.0%	**Yes**
December 2011	94%	99.9%	**Yes**

VSHP TennCare Select Operations	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2011	92%	99.7%	**Yes**
February 2011	96%	99.8%	**Yes**
March 2011	98%	99.9%	**Yes**
April 2011	99%	99.9%	**Yes**
May 2011	98%	99.8%	**Yes**
June 2011	99%	99.9%	**Yes**
July 2011	97%	99.8%	**Yes**
August 2011	96%	99.9%	**Yes**
September 2011	93%	99.8%	**Yes**
October 2011	88%	95.9%	**NO**
November 2011	96%	99.8%	**Yes**
December 2011	93%	99.8%	**Yes**

For the East and West Tennessee Grand Regions and for TennCare Select, VSHP was in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for all months in 2011 with the exception of October 2011.

Management Comments

Management concurs. See response to B.1.

Prompt Pay Results for NEMT Claims

Pursuant to Section 2.22.4 of the CRAs for East and West Tennessee and Section 2.1.i. of the AATS, VSHP is required to comply with prompt pay claims processing requirements in accordance with Tenn. Code Ann.§ 56-32-126(b)(1). In addition, ATTACHMENT XI Section A.15.3 and A.15.4 of the CRAs and ATTACHMENT XIII Section A.15.3 and A.15.4 of 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.

As previously noted, VSHP has contracted with Southeastrans, Inc, (SET) to process NEMT claims. SET achieved monthly compliance with the contractual prompt pay standards for the processing of NEMT claims for the East and West Tennessee Grand Regions and TennCare Select for the calendar year ending December 31, 2011 with the exception of the month of February 2011 in the East Tennessee Grand Region. The prompt pay results for February 2011 NEMT claims processing for the East Tennessee Grand Region were as follows:

NEMT Claims - East Contract	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
February 2011	98%	98.8%	**NO**

Management Comments

Management concurs but would like to note that while the data at face value appeared to be late, further investigation indicates apparent data entry error. The

February 2011 East Region claims failed to meet the prompt payment requirements due to a data entry error on claim batches from two non-emergency transportation providers. The received date for 171 claims were incorrectly entered with the trip date of service as opposed to the actual claims received date which caused the claim payment interval to appear to exceed 60 days. These claims were actually paid in an average of 17 days, but due to the date error appeared to have been paid late. The claims supervisor in place at that time failed to run the proper edit check report needed to catch this error prior to closing. Disciplinary action was taken against the supervisor for this process error.

Prompt Pay Results by the DME Subcontractor

As previously noted, VSHP has contracted with CareCentrix to process DME claims. The following table represents the monthly results of prompt pay testing for DME claims processed by CareCentrix for the East and West Tennessee Grand Regions and TennCare Select for the calendar year ending December 31, 2011:

DME Claims – East Contract	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2011	37%	100.0%	**NO**
February 2011	63%	99.2%	**NO**
March 2011	88%	99.9%	**NO**
April 2011	96%	98.6%	**NO**
May 2011	97%	100.0%	**Yes**
June 2011	90%	99.8%	**Yes**
July 2011	90%	98.7%	**NO**
August 2011	98%	99.7%	**Yes**
September 2011	91%	99.8%	**Yes**
October 2011	42%	55.6%	**NO**
November 2011	98%	99.5%	**Yes**
December 2011	97%	99.5%	**Yes**

DME Claims – West Contract	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2011	30%	99.9%	**NO**
February 2011	69%	98.4%	**NO**
March 2011	85%	99.7%	**NO**
April 2011	96%	98.3%	**NO**
May 2011	96%	99.9%	**Yes**
June 2011	91%	99.8%	**Yes**
July 2011	90%	99.1%	**NO**
August 2011	94%	99.8%	**Yes**
September 2011	92%	99.8%	**Yes**
October 2011	47%	61.1%	**NO**
November 2011	99%	99.5%	**Yes**
December 2011	97%	99.5%	**Yes**

DME Claims – TennCare Select	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2011	67%	100.0%	**NO**
February 2011	84%	99.5%	**NO**
March 2011	95%	99.8%	**Yes**
April 2011	96%	98.9%	**NO**
May 2011	95%	100.0%	**Yes**
June 2011	95%	99.3%	**NO**
July 2011	85%	98.4%	**NO**
August 2011	97%	99.6%	**Yes**
September 2011	92%	99.5%	**Yes**
October 2011	62%	74.8%	**NO**
November 2011	99%	99.8%	**Yes**
December 2011	96%	99.7%	**Yes**

As noted in the tables above, CareCentrix failed to achieve monthly compliance with prompt pay standards for the processing of DME claims for six months in the East and West Tennessee Grand Regions and for TennCare Select for the calendar year ending December 31, 2011.

Management Comments

Management concurs. CareCentrix failed to meet claims processing timeliness in the East Tennessee Grand Region, West Tennessee Grand Region and for TennCare Select during parts of 2011. VSHP has re-evaluated the relationship with CareCentrix, and brought these functions back in-house.

Prompt Pay Results for CHOICES Claims

Pursuant to Section 2.22.4 of the CRAs for the East and West Tennessee Grand Regions and the AATS, VSHP is required to comply with the following prompt pay claims processing requirements for nursing facility claims and for HCBS claims for services other than PERS, assistive technology, minor home modifications, and pest control submitted electronically in a HIPAA-compliant format (CHOICES claims):

- Ninety percent (90%) of clean claims for nursing facility services and HCBS excluding 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.

For the East and West Tennessee Grand Regions and TennCare Select, VSHP achieved monthly compliance with contractual prompt pay standards for the processing of CHOICES claims with the exception of January 2011 for TennCare Select claims. It should be noted only seven CHOICES claims were processed for TennCare Select in January 2011.

The complete results of testing of prompt pay compliance by TDCI can be found at http://www.tn.gov/commerce/tenncare/promptpaybpm.shtml.

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

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

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

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

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

C. Claims Payment Accuracy Reports

Section 2.22.6 of the CRAs for the East and West Tennessee Grand Regions and the AATS requires that 97% of claims are paid accurately upon initial submission. VSHP is required to submit monthly a claims payment accuracy report 21 days following the end of each month. The report includes results for medical claims, CHOICES nursing facility claims and CHOICES HCBS claims. VSHP reported compliance with claims payment accuracy requirement for medical, nursing facility, and HCBS claims for all months for the East and West Tennessee Grand Region and TennCare Select for the calendar year ending December 31, 2011.

Attachment XI Section A.19.5.2. of the CRAs for East and West Tennessee and the AATS requires that 97% of NEMT claims are paid accurately upon initial submission. VSHP is required to submit quarterly a claims payment accuracy report 30 days following the end of each quarter.

SET, the subcontractor processing NEMT claims, provided the following results of claims payment accuracy testing for each quarter by TennCare contracts:

East Contract	Results Reported	Compliance
First Quarter 2011	98%	**Yes**
Second Quarter 2011	98%	**Yes**
Third Quarter 2011	96%	**NO**
Fourth Quarter 2011	98%	**Yes**

West Contract	Results Reported	Compliance
First Quarter 2011	99%	**Yes**
Second Quarter 2011	98%	**Yes**
Third Quarter 2011	96%	**NO**
Fourth Quarter 2011	98%	**Yes**

TennCare Select	Results Reported	Compliance
First Quarter 2011	99%	**Yes**
Second Quarter 2011	96%	**NO**
Third Quarter 2011	95%	**NO**
Fourth Quarter 2011	99%	**Yes**

VSHP's NEMT subcontractor, SET, was not in compliance with the 97% claims payment accuracy requirement for NEMT claims for the third quarter 2011 for East and West Tennessee Grand Regions contracts and second and third quarters 2011 for TennCare Select.

Management Comments

Management concurs but would like to note that Southeastrans' claims payment accuracy fell below 97% during the third quarter of 2011 in the East, West, and TennCare Select primarily due to several public transit trips in which the member did not attend the appointment as scheduled after receiving their bus pass. The VSHP auditor determined that payment for these trips constituted claim payment errors. However, Southeastrans disputed these claim payment errors at the time of the audit report. Since public transit bus passes must be purchased and distributed to members in advance of the scheduled transportation, Southeastrans views this as a member compliance issue as opposed to a claim payment accuracy issue.

The primary payment error in TennCare Select during the second quarter of 2011 was due to ambiguous rate agreement language specific to when the mileage rate should begin. The mileage reimbursement was applied after the tenth (10^{th}) mile, but it should have been applied after the eleventh (11^{th}) mile. The language has been corrected and no further issues are anticipated.

1. Procedures to Review the Claims Payment Accuracy Reports

The review of the claims payment accuracy reports included an interview with VSHP, CareCentrix and SET responsible staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy reports. The review included verification that the number of claims selected by VSHP and SET agreed to requirements of Section 2.22.6.4 of the CRAs for the East and West Tennessee Grand Regions and Section 2.9.12.2 of the AATS, as well as the requirements of the NEMT Attachments Section A.19.5.2. These interviews were followed by a review of the supporting documentation used to prepare the 2011 fourth quarter reports for East, West, TennCare Select and NEMT. All of the claims reported as errors by VSHP and SET were reviewed for verification by TDCI. Twelve claims from the VSHP and SET samples reported as accurately processed by VSHP and SET were also selected for verification by TDCI. For claims that were considered errors, testing focused on the type of error (manual or system) and whether the claim was reprocessed. For claims that were reported as accurately processed by VSHP, TDCI tested these claims to the attributes required in Section 2.22.6.4 of the CRAs for the East and West Tennessee Grand Regions and section 2-9.12.2 of the AATS.

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

No discrepancies were noted in the results of the review of the claims payment accuracy reporting procedures or the claims selected by TDCI for verification.

D. Claims Selected For Testing From Prompt Pay Data Files

The claims sample, consisting of 102 medical claims, 50 CHOICES claims, 17 DME claims, and 10 NEMT claims was judgmentally selected from VSHP's November 2011 prompt pay data files previously submitted to TDCI. The selected claims included high paid dollar claims, adjusted claims, and denied claims. The number of claims selected for testing was not determined statistically; therefore, the results of testing are not intended to represent the percentage of compliance or non-compliance for the total population of claims processed by VSHP.

To verify the completeness of data file submissions, TDCI requests VSHP to provide a reconciliation between the total of all claims processed, including adjusted claims, to the total payments per financial records. For one paid NEMT claim selected for testing, TDCI noted that the paid claim was later adjusted and reprocessed. However, the NEMT prompt pay data files submitted to TDCI by SET have never included adjusted claims. Without adjusted claims, the previously provided prompt pay data files and reconciliations by SET were incomplete and insufficient. SET should ensure all claims, including adjusted claims, are submitted in future prompt pay data files. Also, reconciliations by SET should consider the effect of adjusted claims.

Management Comments

Management concurs. Southeastrans' claim management software in use during the noted time period did not track claim adjustments, and these transactions were documented outside of the system. In March of 2012, Southeastrans replaced the software with a new system that appropriately documents all claim adjustments.

E. Comparison of Actual Claim with System Claim Data

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

For the 179 claims selected for testing and processed by VSHP, SET or CareCentrix, no discrepancies were noted when comparing the claim submitted to data entered into the claims processing systems.

F. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected. For the 10 NEMT and the 17 DME claims selected for testing, no discrepancies related to adjudication accuracy were noted. For the 152 claims processed by VSHP that were selected for testing , the following discrepancies related to adjudication accuracy were noted:

- For seven denied claims, the denial explanation reasons transmitted to the providers did not specify the reason for denial. Four claims denied with the explanation the provider must "refer to billing guidelines for BlueCare or TennCare Select"; two claims denied with the explanation provider must "refer to billing guidelines" and one claim denied with the explanation the provider must "refer to billing guidelines for home health services." These denial reasons do not specifically inform the provider the reason why the claims are denied but rather make a general reference to a comprehensive set of billing instructions. (Control number 9, 14, 28, 42, 72, 73, and 100)

- For one denied claim, the claim was denied with the explanation of "not a valid code for reimbursement." The procedure code was billed by the provider with an invalid modifier for reimbursement. The claim should have been denied explaining that the modifier billed with the procedure code was invalid for reimbursement. (Control number 131)

- For one denied claim, one service line on the claim was incorrectly denied with the explanation exceeds timely filing limits. The claim was appropriately filed

within the timely filing limit of 120 days. (Control number 58)

- For one denied claim, an HCBS service was denied because the number of services provided exceeds the amount prior authorized by VSHP's care management system. The claim was submitted by the provider through an electronic verification system (EVV) operated through a VSHP subcontractor. The EVV authorizes VSHP's providers to deliver HCBS services based on the plan of care received from VSHP's care management system. The EVV telephonically verifies HCBS visits by providers. After the visit is confirmed, providers utilize the EVV to electronically submit claims to VSHP for payment. The EVV system failed to properly enforce the authorization limits as determined by VSHP's care management system. Without the enforcement of authorization limits, providers are allowed to bill for services contrary to the amount of services specified in the enrollee's plan of care. (Control number 18)

Management Comments

- Management concurs. VSHP is currently reviewing all codes with a general "refer to billing guidelines" explanation, and will ensure that more specific explanations are used moving forward. This project is scheduled to be completed by the end of 2012.

- Management concurs. VSHP is developing an explanation code that states "invalid procedure/modifier combination" that will replace the referenced explanation code. The new explanation code should be in place by the end of 2012.

- Management concurs. This was the result of a processor error. The claim should have denied for a Medicare Summary Notice.

- Management concurs. This was due to an authorization that had a modified start date in the EVV system which caused the modified authorization to appear to be a new authorization. The system then allowed a submission of services over and above the authorized amount. See C.4 response for additional details.

G. Price Accuracy Testing

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

For the 179 claims processed by VSHP, SET or CareCentrix that were selected for testing, no discrepancies were noted related to pricing accuracy.

H. Copayment Testing

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

TDCI requested a listing of 100 enrollees with the highest accumulated copayments assessed for the period January 1, 2011 through December 31, 2011. Five of the enrollees' claims from the listing were reviewed through the claims processing system for the accurate application of copayment requirements. No discrepancies were noted.

I. Remittance Advice Testing

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

The examiners requested VSHP to provide ten remittance advices selected from claims processed by VSHP, ten from NEMT claims processed by SET and ten from DME claims processed by CareCentrix to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers. No discrepancies were noted between the claims payments per the claims processing system and the related information communicated to the providers for the 30 claims processed by VSHP, SET or CareCentrix.

The following statement was found on each of the remittance advices for CareCentrix claims selected for testing: "Reminder: All provider claims must be received by CareCentrix within 45 days unless otherwise specified by State law." The statement is contrary to timely the filing limit of 120 days per the CRAs for East and West Tennessee and the AATS. The statement on future remittance advices should be modified to state the timely filing requirement specific to claims submitted by TennCare providers.

Management Comments

Management concurs. CareCentrix has since modified their EOP language by adding the phrase "unless otherwise specified by state law" to accommodate laws that may require a longer timeframe for claim submission and administer to a 120 day claim submission timeframe for VSHP business.

J. Analysis of Cancelled Checks

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

TDCI requested VSHP to provide eight cancelled checks and proof of payment for two electronic funds transfers from medical claims tested. The check or electronic transfer amounts agreed with the total amount paid per the remittance advice. No pattern of significant lag times between the issue date and the cleared date was noted.

Additionally, TDCI requested both SET and CareCentrix to provide ten cancelled checks from claims tested. SET and CareCentrix provided the cancelled checks. The check amounts agreed with the total amount paid per the remittance advice. No pattern of significant lag times between the issue date and the cleared date was noted.

K. Pended and Unpaid Claims Testing

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

The VSHP, SET and CareCentrix pended and unpaid data files as of December 31, 2011 for the East and West Grand Regions and TennCare Select were reviewed for claims which exceeded 60 days old. The number of pended and unpaid claims per these data files indicates no material liability existed for claims over 60 days old as of that date.

L. Mailroom and Claims Inventory Controls

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

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

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints 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 states:

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

Ten VSHP and five SET provider complaints were judgmentally selected from the December 2011 provider complaint logs provided by VSHP and SET. For the ten provider complaints tested for VSHP and the five complaints tested for SET, VSHP and SET responded timely in accordance with requirements of Tenn. Code Ann. § 56-32-126.

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, 2011, TDCI received and processed 46 provider complaints against VSHP. The responses by VSHP to providers were categorized by TDCI in the following manner:

Denial Upheld by VSHP	16
Issue of Concern was Resolved	4

Denial Reversed by VSHP	20
VSHP Answered Provider's Question	4
VSHP Agreed Partially to Provider Complaint Issue	2

TDCI judgmentally selected 10 provider complaints submitted to TDCI for review. The complaints were reviewed by analyzing issues raised by the provider. Questions were posed to VSHP for response. Emphasis was placed on discovering deficiencies in the VSHP's claims processing system or provider complaint procedures. The detailed review of the provider complaints including TDCI questions and VSHP responses can be found in Appendix 1 of this report. As a result of the review of provider complaints submitted to TDCI, no significant issues were noted in VSHP's claims processing system or provider complaint procedures.

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, 2011, five independent reviews were initiated by providers against VSHP. The following is a summary of the outcomes of independent reviewer filings:

Decision for Provider	1
Provider Submission Ineligible for Independent Review	2
VSHP Settled with Provider before Decision Rendered	2

TDCI judgmentally selected three independent reviews for testing. The independent reviews were analyzed for issues raised by the provider. 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. The detailed testing of the independent reviews including TDCI questions and VSHP responses can be found in Appendix 2 of this report. As a result of the review of

processed independent reviews, no significant issues were noted in VSHP's claims processing system or provider complaint and appeal 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. VSHP updates quarterly the provider administration manual through provider newsletters. The provider administration manual and the quarterly newsletters were submitted by VSHP and prior approved by TDCI for the calendar year 2011. VSHP's provider administration manual is incorporated by reference into each of VSHP's agreements with providers. Updates to the provider administration manual amend the provider agreements and, therefore, require compliance with the requirements of the AATS, and Section 2.12.9.43 of the CRAs for the East and West Tennessee Grand Regions. These contracts require that VSHP:

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

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

TDCI reviewed documentation tracking the mailings of the first quarter 2011 provider quarterly update to the provider administration manual and found that VSHP maintained documentation of the receipt notifications to providers.

E. Provider Agreements

Agreements between an HMO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO as provided by Tenn. Code Ann. § 56-32-103(b)(4). The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-103(c)(1). Additionally, the

TennCare Bureau has defined through contract with the HMO minimum language requirements to be contained in the agreement between the HMO and medical providers. These minimum contract language requirements include, but are not limited to: standards of care, assurance of TennCare enrollees' rights, compliance with all federal and state laws and regulations, and prompt and accurate payment from the HMO to the medical provider.

Per Section 2.12.2 of the AATS and the CRA for the East and West Tennessee Grand Region between VSHP and the TennCare Bureau, all template provider agreements and revisions thereto must be approved in advance by TDCI, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Additionally, Section 2.18. of the AATS and Section 2.12.9 of the CRAs for the East and West Tennessee Grand Regions set forth the minimum language requirements for provider agreements.

TDCI judgmentally selected 10 contracted providers from the claims selected for testing in Section VII.D. of this report. The contracts selected varied by provider types including hospitals and behavioral health providers. TDCI requested the executed contracts be available for inspection during fieldwork.

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

The following deficiency was noted:

- For one transportation provider agreement, the executed agreement did not agree with version prior approved by TDCI.

  Management Comments

  Management concurs. The language addressing payment for member "no-shows" was removed from the provider agreement in question for unexplainable reasons. The Southeastrans Director of Operations who executed the agreement in question is no longer employed by Southeastrans, complicating their ability to determine why the language was removed. Southeastrans will execute a new contract with this provider using the template approved by the Tennessee Department of Commerce and Insurance.

F. Provider Payments

Capitation payments to providers were tested during 2011 to determine if VSHP complied with the payment provisions set forth in its capitated provider agreements.

Review of payments to capitated providers indicated that all payments were made per the provider contract requirements in a timely manner.

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 2.17 of the AATS, and 2.26.3 of the CRAs for East and West Tennessee Grand Regions, all template subcontractor agreements and revisions thereto must be approved in advance in writing by TDCI, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. There were no deficiencies found during the review of subcontract testing.

H. Non-discrimination

Section 2.24 of the AATS, and Section 2.28 of the CRAs for the East and West Tennessee Grand Regions, require VSHP to demonstrate compliance with Federal and State regulations of Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1983, Title II of the Americans with Disabilities Act of 1990, the Age of Discrimination Act of 1985 and the Omnibus Budget Reconciliation Act of 1981. Based on discussions with VSHP staff and a review of policies and related supporting documentation, VSHP was in compliance with the non-discrimination reporting requirements of the TennCare contracts.

I. Internal Audit Function

The importance of an internal audit function is to provide an independent review and evaluation of the accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. An internal audit function is responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. The internal audit department should report directly to the board of directors so the department can maintain its independence and objectivity. No deficiencies were noted in review of the organization or activities of the internal audit department.

J. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., Title 56, Chapter 11, Part 2 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-105 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system or health maintenance organization

holding company system shall register with the commissioner…." No deficiencies were noted in the review of Holding Company compliance requirements.

K. Contract to Audit Accounts

VSHP is required to submit annual audited financial statements by May 1 for the preceding calendar year. Section 2.10.8 of the AATS, and Section 2.21.11.2 of the CRAs for the East and West Tennessee Grand Regions require such audits to be subject to prior approval of the Comptroller of the Treasury and to be submitted on the standard "Contract to Audit Accounts" agreement. The "Contract to Audit Accounts" between the Comptroller of the Treasury and the external auditor defines the standards for which the audits are to be performed. VSHP has complied with this provision.

L. Conflict of Interest

Section 6.7. of the AATS, and Section 4.19 of the CRAs for the East and West Tennessee Grand Regions warrant that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to VSHP in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration. Additionally, Section 1.4 of the AATS and Section 2.26.7of the CRAs for the East and West Tennessee Grand Regions require VSHP to ensure that subcontractors comply with all applicable requirements of the CRA including conflict of interest requirements.

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

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

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

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

- The most recently approved provider agreement templates contain the conflict of interest language of the CRAs.

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

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

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

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

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

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

M. CHOICES

As previously mentioned, effective March 1, 2010, the AATS and effective August 1, 2010, the CRAs for East and West Tennessee Grand Regions were amended for the implementation of the CHOICES program. CHOICES is TennCare's program for long-term services and supports (LTSS). LTSS 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. Prior to implementation, VSHP was required to contract with nursing facilities providing services for assigned enrollees. Additionally, VSHP agreed to implement an electronic visit verification system (EVV) which telephonically verifies HCBS visits by providers. The following deficiencies were noted related to the CHOICES program administration:

- Beginning in August 2010, VSHP experienced difficulties in implementing the requirements of the CHOICES program in the East and West Tennessee

Grand Regions. Audits by the TennCare Bureau resulted in the assessment of liquidated damages of $13,050,000 for the CHOICES program. The audits noted VSHP's failure to document contact with new members and the establishment of referrals.

Management Comments

Management concurs. VSHP was placed on a Corrective Action Plan due to the findings listed. All of the elements of the Corrective Action Plan were implemented successfully and confirmed in an audit of Referrals and New Members conducted in July of 2011. TennCare subsequently removed the Corrective Action Plan in August of 2011. VSHP has successfully passed all Referral and New Member audits that have been conducted since that time.

- TDCI also noted in Section VII.F. of this report the following issue related to the CHOICES Program:

  For one denied claim processed by VSHP, an HCBS service was denied because the number of services provided exceeded the amount prior authorized by VSHP's care management system. The claim was submitted by the provider through the EVV operated through a VSHP subcontractor. The EVV authorizes VSHP's providers to deliver HCBS services based on the plan of care received from VSHP's care management system. The EVV telephonically verifies HCBS visits by providers. After the visit is confirmed, providers utilize the EVV to electronically submit claims to VSHP for payment. The EVV system failed to properly enforce the authorization limits as determined by VSHP's care management system. Without the enforcement of authorization limits, providers are allowed to bill for services contrary to the amount of services specified in the enrollee's plan of care. (Control number 18)

  Management Comments

  Management concurs. The issue in question is very complex and occurs when we "void" an authorization in the Q System. In those situations, the voided authorization does not automatically "void" the corresponding authorization in the EVV system. Rather, it creates a second authorization and is in turn interpreted by the Sandata system to be a "unique" transaction due to the type of field being changed in the EVV system. Consequently, if we modify an authorization and do not make any changes to the "unique" fields, the second/corrected authorization will either (1) void the initial authorization in the EVV system or (2) cause the EVV system to assume that the second/corrected authorization is actually a new authorization and to treat it as such. Since this phenomenon is random and does not occur every time we void an authorization, it was extremely difficult to identify and

replicate. However, we have identified a mitigation plan to rectify the historical issues and multiple options to mitigate the problem prospectively from a systematic point of view. VSHP will implement the corrective actions on or before December 15, 2012.

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

Appendix 1

Details of the Review of Provider Complaints Submitted to TDCI (See Section VIII.B.)

2011.080 - Rehab facility complained that inpatient stay was inappropriately denied by VSHP for lack of prior authorization.

- VSHP Response: VSHP reversed the denial and paid the claim.
    - TDCI's Follow-up Question: Why was the claim denied?
- VSHP's Comments/Follow-up: Processor denied without reviewing approved authorization.

2011.085 - Hospital complained that an inpatient readmission within 30 days was inappropriately denied. VSHP had denied because the readmission occurred within 30 days of a previous inpatient stay.

- VSHP Response: After further review of the medical records by our nurse consultant, the decision was made to overturn the denial and process the claim for payment.
    - TDCI's Follow-up Question: Why was the claim originally denied?
- VSHP's Comments/Follow-up: The authorization for the readmission was approved, but the claim was denied based on the readmission policy.

2011.095 - Physician group complained VSHP incorrectly recouped an amount that caused the claim to be paid at less than the correct reimbursement rate. Provider attempted to submit corrected claims but VSHP denied for timely filing.

- VSHP Response: VSHP adjusted claims to reflect the correct reimbursement rate.
    - TDCI's Follow-up Question: Why did the claim require recoupment? Why was the corrected claim denied?
- VSHP's Comments/Follow-up: VSHP adjusted the claim incorrectly on second processing. The new claim was denied for timely filing; however, we should have denied this claim as a duplicate as the claim had already been paid.

2011.139 - Pulmonary physicians group complained that VSHP incorrectly denied a claim for lack of prior authorization. The group relies on the hospital to obtain the authorization from VSHP.

- VSHP Response: The claims in question have already been reviewed and reprocessed for payment.
    - TDCI's Follow-up Question: Why were these claims denied?
- VSHP's Comments/Follow-up: No authorization was on file on date of original submission. A provider appeal by the hospital for an inpatient stay was reviewed and overturned in the appeals department and the claim was adjusted per approved authorization now on file.

2011.215 - Hospice provider complained VSHP inappropriately denied for other insurance coverage and after several resubmissions denied for timely filing. Other insurance coverage is Medicare administered by Humana. The claim was denied by Humana.

- VSHP Response: VSHP reviewed the complaint and based on our research with Humana, the decision was made to overturn the denial. After speaking with Humana, they advised us they do not cover for Hospice benefits.
    - TDCI's Follow-up Question: Why was this denied?
- VSHP's Comments/Follow-up: Claim correctly denied for lack of explanation of benefits from other insurance as the member had Medicare via Humana. Medicare does not cover hospice room and board, but still VSHP needs an explanation of payment from Humana. After we called Humana, we were told they do not cover Hospice benefits.

2011.298 - Pediatric group complained that VSHP is incorrectly seeking recoupment of money directly from the provider when they should have taken a "pay and chase" action.

- VSHP Response: VSHP reviewed the complaint and agreed they had sent out a refund request in error after receiving an Explanation of Benefits (EOB) from another insurance carrier. VSHP read the EOB incorrectly and have cancelled the refund request.
    - TDCI's Follow-up Question: Why was this claim denied?
- VSHP's Comments/Follow-up: A refund request was sent to the other insurance carrier and they provided an Explanation of Benefits back to us showing how the claim was processed. According to the explanation of benefits, the claim was paid correctly.

2011.171 - Hospice provider complained that VSHP denied claims for exceeding timely filing limits.

- VSHP Response: VSHP upheld its decision after review and found no valid proof of timely filing.
    - TDCI's Follow-up Question: None.

2011.109 - Hospital complained that VSHP incorrectly denied claim because patient's condition did not meet inpatient criteria.

- VSHP Response: VSHP upheld its decision. No additional medical records were submitted with complaint.
    - TDCI's Follow-up Question: None.

2011.219 - Home Health provider complained that VSHP and UnitedHealthCare are paying only out-of-network reimbursement rates. The provider obtained a referral from VSHP however UnitedHealthCare is the primary insurer. The provider is not a participating provider with UnitedHealthCare. VSHP paid only the out-of-network deductible based on UnitedHealthCare out-of-network reimbursement rate.

- VSHP Response: VSHP upheld its previous processing decision. VSHP contacted UnitedHealthCare and they indicated they had a contract with the provider to accept UnitedHealthCare's out-of-network discount. VSHP processed the claims and have paid up to the member's liability which is correct according to our Third Party Liability guidelines in the VSHP Provider Administration Manual.
    - TDCI's Follow-up Question: None.

2011.310 - Physician group complained VSHP incorrectly recouped a previously paid claim. VSHP had recouped the claim since it had discovered the member had other insurance. Provider submitted the claim to other insurance carrier but it was denied as a duplicate claim by the other insurance carrier.

- VSHP Response: VSHP upheld its prior denial of the claim. The member has other insurance coverage which is primary.
    - TDCI's Follow-up Question: None.

Appendix 2

Details of Testing of Independent Reviews (See Section VIII.C.)

IR 10-020 - Issue and Independent Review (IR) Decision: A hospital alleged VSHP incorrectly denied claim because services did not meet the criteria for an inpatient admission. The Independent Reviewer issued a decision in favor of the provider.

- TDCI's Follow-up Question: Is there a policy regarding this in VSHP's provider manual or is this included in the Contractor Risk Agreement?
    - VSHP Response: This decision was based on the Milliman Care Guidelines.

IR 10-038 - Issue and IR Decision: A provider's claims were not filed within 120 days since an error by Medicare caused the delay. VSHP settled with the provider prior to the Independent Reviewer decision. VSHP noted the delay was due to an error by Medicare and not the provider.

- TDCI's Follow-up Question: None.

IR 10-094 - Issue and IR Decision: Hospital alleged VSHP incorrectly denied inpatient claim for lack of prior authorization. VSHP settled with the provider prior to the Independent Reviewer decision. The hospital had sent additional medical records with the independent review submission not previously submitted in a provider appeal to VSHP.

- TDCI's Follow-up Question: Why didn't the provider send the VSHP all the medical record information on VSHP's initial request?
    - VSHP Response: Unsure of the provider's reasoning.