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

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

OF

THE TENNCARE OPERATIONS

OF

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

d/b/a AMERICHOICE

NASHVILLE, TENNESSEE

FOR THE PERIOD JANUARY 1, 2007
THROUGH JUNE 30, 2007

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DATE: May 8, 2008

The examination fieldwork for a Limited Scope Financial and Compliance Examination and Claims Processing Market Conduct Examination of the TennCare Operations only of UnitedHealthCare Plan of the River Valley, Inc., Nashville, Tennessee, was completed October 26, 2007. The report of this examination is herein respectfully submitted.

I. FOREWORD

On September 13, 2007, the TennCare Oversight Division of the Tennessee Department of Commerce and Insurance (TDCI) notified representatives of the TennCare operations of the

UnitedHealthcare Plan of the River Valley, Inc. (UPRV) d/b/a AmeriChoice of its intention to perform a market conduct, and limited scope financial statement, and compliance examination. Fieldwork began on October 15, 2007 and ended on October 26, 2007.

This report includes the results of the market conduct examination "by test" of the claims processing system for UPRV's TennCare operations. Further, this report reflects the results of a limited scope examination of financial statement account balances as reported for TennCare operations by UPRV. This report also reflects the results of a compliance examination for its TennCare operations of UPRV's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of the TennCare operations of UPRV was conducted jointly by TDCI and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 3-6. of the Contractor Risk Agreement (CRA) for the East Tennessee Grand Region and Section 2.25 of the CRA for the Middle Tennessee Grand Region between the State of Tennessee and UPRV, Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) § 56-32-215 and § 56-32-232.

UnitedHealthCare Plan of the River Valley, Inc. (formerly known as John Deere Health Plan, Inc.) is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

During 2004, the Illinois Department of Insurance conducted a full scope financial examination of UPRV then known as John Deere Health Plan, Inc., because the company is domiciled in Illinois. The Tennessee Department of Commerce and Insurance received and accepted Illinois' Report of Examination dated March 22, 2004. As a result, this division did not conduct a complete financial examination of UPRV as part of this examination. The limited scope financial examination focused on selected balance sheet accounts and the TennCare income statement as reported for UPRV's TennCare operations submitted with its National Association of Insurance Commissioners (NAIC) Second Quarterly Statement as of June 30, 2007, the Medical Services Monitoring Report for the East Tennessee Grand Region as of June 30, 2007, and the Medical Loss Ratio Report for the Middle Tennessee Grand Region as of June 30, 2007.

The current market conduct examination by TDCI and the Comptroller focused on the claims processing functions and performance for UPRV TennCare operations. The testing included an examination of internal controls surrounding claims adjudication,

claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers. Additional testing was performed as a follow-up to a TDCI readiness review for the Middle Tennessee operations which began April 1, 2007.

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

Fieldwork was performed using records provided by UPRV for TennCare operations before and during and after the onsite examination from October 15, 2007 through October 26, 2007.

C. Purpose and Objective

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

The objectives of the examination were to:

- Determine whether UPRV met certain contractual obligations under the CRA and whether UPRV was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-201 *et seq.*;

- Determine whether UPRV had sufficient financial capital and surplus to ensure the uninterrupted delivery of health care services for its TennCare members on an ongoing basis;

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

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

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

III. PROFILE

A. Administrative Organization

Heritage National Healthplan, Inc. (HNHI), an Illinois HMO, was incorporated under the laws of the State of Illinois on August 5, 1985, and was licensed as an HMO by

the State of Illinois Department of Insurance in 1985. HNHI was licensed as an HMO by the State of Tennessee Department of Commerce and Insurance on June 20, 1995. HNHI was a wholly-owned subsidiary of John Deere Health Care, Inc., (JDHC) which was a wholly-owned subsidiary of Deere & Company (Deere).

Heritage National Healthplan of Tennessee, Inc. (HNHT), a Tennessee health maintenance organization, was incorporated under the laws of the State of Tennessee on October 25, 1985, and was thereafter licensed as an HMO by the State of Tennessee Department of Commerce and Insurance on July 1, 1986. Under its license, HNHT administered commercial plans and also participated as a contracted HMO in the TennCare program.

On September 10, 1996, HNHT, submitted to the State of Tennessee Department of Commerce and Insurance a proposed plan to merge with and into HNHI. On November 18, 1996, the merger of HNHT with and into HNHI was approved by the Commissioner of the Tennessee Department of Commerce and Insurance to be effective December 31, 1996. Effective July 1, 1999, HNHI changed its name to John Deere Health Plan, Inc. which was a wholly-owned subsidiary of Deere & Company.

On December 6, 2005, Deere & Company entered into a stock purchase agreement with United Healthcare, Inc. for the sale of JDHC and its subsidiaries. Effective February 24, 2006, JDHC became a wholly-owned subsidiary of United Healthcare Inc. JDHC changed its name to UPRV. UPRV is a wholly-owned subsidiary of UnitedHeathcare Services Company of the River Valley, Inc. (USCRV). USCRV is a wholly-owned subsidiary of UnitedHealthcare Services, Inc., a wholly-owned subsidiary of United Healthcare, Inc.

In addition to TennCare operations, UPRV has Medicare and commercial lines of business in Tennessee, as well as in other states.

The officers and directors or trustees for UPRV at June 30, 2007, were as follows:

Officers for UPRV

Richard Lowell Bartsh, M.D., President
James Allan Cousins, Treasurer
Victoria Jane Graves, Secretary

Other Officers for UPRV

Bruce Chase Steffens, M.D., Chief Medical Officer
Daniel Roger Kueter, Executive Vice President

Directors or Trustees for UPRV

Richard Lowell Bartsh, M.D., James Edward Hecker

William Kenneth Appelgate, PhD.	Cathie Sue Whiteside
Victoria Jean Kauzlarich	Forrest Gregory Burke
William Ernest Moeller	James Alan Cousins
Bruce Chase Steffens, M.D.	Thomas Patrick Wiffler

B. Brief Overview

UPRV has served TennCare enrollees in the East Tennessee Grand Region since the inception of the TennCare program in January 1994 under the CRA between John Deere Health Plan and the TennCare Bureau. Effective April 1, 2007, UPRV expanded TennCare operations into the Middle Tennessee Grand Region.

Effective July 1, 2002, the CRA with UPRV was amended for UPRV to temporarily operate under a non-risk agreement for the East Tennessee Grand Region. This period, otherwise known as the "stabilization period," was established to allow all MCOs a satisfactory period of time to establish financial stability, maintain continuity of a managed care environment for enrollees and assist the TennCare Bureau in restructuring the program design to better serve Tennesseans adequately and responsibly. UPRV agreed to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures as they existed April 16, 2002, unless such a change received approval in advance by the TennCare Bureau.

During stabilization for the East Tennessee Grand Region operations, UPRV receives from the TennCare Bureau a monthly fixed administrative payment based upon the number of TennCare enrollees assigned to UPRV. The TennCare Bureau reimburses UPRV for the cost of providing covered services to TennCare enrollees.

For the Middle Tennessee Grand Region effective since April 1, 2007, UPRV 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 UPRV and each enrollee's eligibility classification.

UPRV is managed by USCRV, pursuant to a service agreement. Per this service agreement, all TennCare fixed administrative payments received by UPRV for the East Tennessee Grand Region are remitted to USCRV in exchange for all management services. For the Middle Tennessee Grand Region, UPRV pays a management fee to USCRV equal to 9% of the monthly capitation payments received from the TennCare Bureau. UPRV also pays United Behavioral Health, Inc. (UBH), a related party, a per member per month fee for the administration of behavioral health services.

For the period January 1, 2007 through June 30, 2007, UPRV received 42% of its nationwide revenue and 61% of its Tennessee revenue, from payments for providing medical benefits to TennCare members. As of June 30, 2007, UPRV had approximately 80,000 TennCare members for the East Tennessee Grand Region and had approximately 178,000 for the Middle Tennessee Grand Region.

C. Claims Processing Not Performed by UPRV

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

- Dental
- Pharmacy
- Behavioral Health for the East Tennessee Grand Region

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

- Vision for East Tennessee Grand Region – Davis Vision, Inc.
- Vision for Middle Tennessee Grand Region – Spectera, Inc., a related party to UPRV
- Behavioral Health for Middle Tennessee Grand Region – UBH, a related party to UPRV.

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, 2003 through December 31, 2003:

A. Claims Processing Deficiencies

1. JDHP [now UPRV] did not process claims timely in accordance with Tenn. Code Ann. § 56-32-226(b) for the months of July 2003 through January 2004.

2. The data recorded in JDHP's claims processing system for 2 of the 60 claims tested did not contain all of the required elements of encounter data reporting.

3. Two claims did not pay at the correct rate.

Finding number 3 above is repeated as part of this report.

B. Compliance Deficiencies

1. JDHP did not always respond to provider complaints within the timeframe dictated in their correspondence with the provider. For nine of the ten provider complaints tested, JDHP did not respond within 45 days with a written notification of a decision as specified in correspondence by JDHP.

2. The three provider agreements selected for testing did not include all provisions required by Section 2-18. of the Contractor Risk Agreement.

3. Two of the three executed provider agreements tested did not use the current provider template approved by TDCI.

4. Subcontracts for major medical services between JDHP and Davis Vision and JDHP and Quality Transportation were not approved by TDCI prior to execution.

5. JDHP did not return interest generated from the deposit of state funds held for provider payments as required by Section 2-9.e.5. of the Contractor Risk Agreement.

Findings numbered 2, 3, 4, and 5 above are repeated as part of this report.

V. SUMMARY OF CURRENT FINDINGS

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

A. Financial Deficiencies

1. The following deficiencies were noted in the preparation of the TennCare operating statement for the East Tennessee Grand Region:

   - UPRV reported $85,736,072 premium revenue for the non-risk East Tennessee Grand Region. This does not agree to the total of all payments received from the TennCare Bureau for the period January 1, 2007 through June 30, 2007 of $90,222,320.

   - The amount reported as investment income is based on an allocation derived from the administrative revenue received from the TennCare Bureau compared to total company premiums. This method of allocation for investment income does not appear reasonable.

   (See Section VI.B.1)

2. The following deficiencies were noted in the preparation of the TennCare operating statement for the Middle Tennessee Grand Region:

   - The amount reported as investment income is based on a previously budgeted amount for pro forma income statements submitted to the TennCare Bureau as a requirement for the significant expansion into Middle Tennessee. This method of allocation for reporting investment income does not appear reasonable.

   - Expenses paid to UBH for the administration of behavioral health services

were incorrectly excluded from administrative expenses.

(See Section VI.B.2)

C. Claims Processing Deficiencies

1. During fieldwork, it was determined that UPRV had not submitted to TDCI data files for claims processed by all subcontractors in determining prompt pay compliance. Davis Vision processes vision claims for UPRV in the East Tennessee Grand Region, but the original data file submissions to TDCI did not include claims processed by Davis Vision. After fieldwork, UPRV submitted data files for the subcontractor from January 2007 through the current period. (See Section VII.A.)

2. The follow-up review to the implementation of the Middle Tennessee TennCare product on April 1, 2007, finds the problems encountered during the implementation did not materially impact accuracy and timeliness of claims processing. However, UPRV should continue to work through the remaining issues identified by UPRV on the post implementation issues log. (See Section VII.C.)

3. The following deficiencies were noted during the review of the procedures to prepare claims payment accuracy reports:

   - UPRV failed to include in the claims payment accuracy samples the vision claims processed by their subcontractors in both the East Tennessee Grand Region and the Middle Tennessee Grand Region.

   - The reports are not prepared by UPRV's Internal Audit Department, but rather by a Quality Assurance Unit within UPRV's Claims Operations Department. Initial resolution between the Claims Department staff and Quality Assurance staff in Moline, Illinois, does not involve input from staff based in Tennessee.

   - When testing claims for claims payment accuracy, the CRA requires the plan to compare payments to the contracted rate. UPRV did not test to the contracted rate for all claims selected.

   - When testing claims for claims payment accuracy, the CRA requires the plan to determine if the member's eligibility at processing date was correctly applied. UPRV's procedure for this attribute was only to verify the social security number.

   (See Section VII.D.)

4. For the 129 claims selected for testing for the Middle Tennessee Grand Region, the following discrepancies related to adjudication accuracy were noted:

   - For eight of the adjusted claims selected for testing, UPRV denied the claims on initial processing based on the fact that the enrollee also had Medicare coverage. For all eight of the claims tested, the services were non-covered services by Medicare. UPRV made a policy change on August 13, 2007 to allow certain procedures that will never be covered by Medicare to be processed as primary without waiting for a Medicare explanation of benefits.

   - For five of the adjusted claims selected for testing, the claims processor selected the incorrect provider number and associated fee schedule on first processing.

   - Five of the denied claims tested were improperly denied due to manual processing errors because the claims processing policies and procedures were not correctly applied.

   - Three of the denied claims tested were denied with the explanation that the member was not eligible on the date of service; however, the three enrollees were actually retroactively eligible for TennCare before the start of operations, April 1, 2007. UPRV is contracted to manually process claims and reimburse providers for covered services incurred prior to April 1, 2007.

   - Six of the denied claims selected were properly denied; however, the explanation reason communicated to the provider did not adequately explain the reason the claim was denied.

   (See Section VII.G.)

5. For the 129 claims selected for testing for the Middle Tennessee Grand Region, the following pricing accuracy discrepancies were noted.

   - Seven of the adjusted claims tested for emergency ambulance services were incorrectly paid. The fee schedule associated with these claims was incorrectly configured to pay $0 for each trip charge and $0.01 per each mile instead of at the established non-participating rates.

   - Eight of the paid claims tested for one hospital incorrectly paid when the service was contracted to pay on the reimbursement methodology known as diagnosis related group (DRG). An external tool was utilized to price the DRG payment, but the external tool did not agree to the terms of the executed provider contract. (See Section VII.H.)

C. <u>Compliance Deficiencies</u>

1. The plan is currently operating in the East Tennessee Grand Region with an

unapproved provider manual. Additionally, a separate provider manual for Davis Vision, Inc. has never been submitted to TDCI for approval. (See Section VIII.B.)

2. For three of the four provider agreements selected for testing for the East Tennessee Grand Region, the following deficiencies were noted:

   - A hospital provider agreement was signed in October 2001. The agreement is deemed materially out of compliance with provider agreement language requirements of Section 2-18. of the CRA for East Tennessee Grand Region since numerous language revisions have been required for provider agreements since 2001.

   - An ancillary provider agreement was signed in December 2005 using a template approved as of September 2004. The agreement is deemed materially out of compliance with provider agreement language requirements of Section 2-18. of the CRA for East Tennessee Grand Region since numerous language revisions have been required for provider agreements since September 2004.

   - A unique ancillary provider agreement was executed in June 2004. This agreement has never been submitted to TDCI for approval as a material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). The agreement is deemed materially out of compliance with provider agreement language requirements of Section 2-18. of the CRA for East Tennessee Grand Region since numerous language revisions have been required for provider agreements since June 2004.

   (See Section VIII.C.)

3. A physician group provider agreement was signed in May 2001 to operate in the East Tennessee Grand Region. The provider operates in both the East and Middle Tennessee Grand Regions. The agreement is deemed materially out of compliance with provider agreement language requirements of Section 2-18. of the CRA for East Tennessee Grand Region since numerous language revisions have been required for provider agreements since May 2001. This provider has not been contracted to provide services in the Middle Tennessee Grand Region, but UPRV has included this provider in its Middle Tennessee provider directory. UPRV was cautioned numerous times during the approval process for the expansion into the Middle Tennessee Grand Region that if East Tennessee providers also provide services in the Middle Tennessee Grand Region, a separate provider agreement must be executed for each region. (See Section VIII.C.)

4. A community mental health center (CMHC) is contracted through an approved provider agreement template; however, UPRV and the CMHC executed a separate promissory note agreement. The promissory note agreement has was not submitted to TDCI for prior approval in violation of Tenn. Code Ann. § 56-32-

203(c)(1). (See Section VIII.C.)

5. The following deficiencies were identified in the subcontracts tested:

    - One subcontract for the administration of vision services in the East Tennessee Grand Region, including credentialing services and the payment of vision claims, was prior approved by TDCI in October 2004.

        - The subcontractor contracts directly with providers of vision services. UPRV has not submitted the provider agreement between the subcontractor and vision providers for prior approval.

        - The vision subcontractor's provider manual has never been submitted to TDCI for approval in violation of Tenn. Code Ann. § 56-32-203(c)(1).

        - The contract was amended in November 2004, but the amendment was not submitted to TDCI for approval in violation of Tenn. Code Ann. § 56-32-203(c)(1) and Section 2-9. of the CRA for East Tennessee Grand Region.

    - An affiliated company provides subrogation recovery services in both East and Middle Tennessee Grand Regions. No subcontract has been submitted to TDCI for prior approval which would allow the payment for these services to a related party in violation of Tenn. Code Ann. § 56-32-203(c)(1).

    (See Section VIII.E.)

6. The following deficiencies were noted in the review of the internal audit function for UPRV's TennCare operations:

    - Section 2-9.m.2. of the CRA for the East Tennessee Grand Region and Section 2.22.6.2 of the CRA for Middle Tennessee Grand Region require the claims payment accuracy reports be prepared by the plan's Internal Audit Department. The reports are not prepared by UPRV's Internal Audit but rather by a Quality Assurance Unit within UPRV's Claims Operations Department.

    - As of the last day of examination field work, focused reviews of compliance with the requirements of the CRAs for East and Middle Tennessee Grand Regions had not been performed by Internal Audit. The Annual Audit plan submitted by UPRV to the TennCare Bureau indicated an internal audit has been scheduled in January 2008.

    - The Annual Audit Plan reported that the results of various audits performed will be reported to the Compliance Officer and the Chief Financial Officer at the Tennessee plan. The results of the various audits should also be

presented timely to UPRV's board of directors.

(See Section VIII.G.)

7. When UPRV requests funding for medical claims processed in the East Tennessee Grand Region, it requests from the TennCare Bureau the cash to be paid at the time of processing plus any amounts of withholds computed. The request of the withhold is a violation of Section 3-10.h.2.(b) of the CRA for the East Tennessee Grand Region, since the funds are not released to providers within 24 hours. In addition, Section 3-10.h.2.(d) of the CRA for the East Tennessee Grand Region states interest generated by funds on deposit for provider payments related to the non-risk agreement period shall be the property of the State. UPRV should remit to the TennCare Bureau all interest earned from all withholds held for TennCare operations for the East Tennessee Grand Region related to dates of service since July 1, 2002, the beginning of the non-risk operations.
(See Section VIII.J.2.)

8. Funds related to outstanding checks for payments related to the non-risk agreement period are maintained in an interest bearing account. UPRV has failed to remit to the TennCare Bureau the interest earned on these funds in violation of Section 3-10.h.2.(d) of the CRA for the East Tennessee Grand Region. This finding was previously noted in the prior examination by TDCI and remains uncorrected.
(See Section VIII.J.4.)

9. UPRV has not complied with Section 2-10.h.4. of the CRA for East Tennessee Grand Region and Section 2.21.10.2 of the CRA for the Middle Tennessee Grand Region that require UPRV's external auditor to execute an agreement with the Comptroller of the Treasury. The agreement must be submitted on the standard "Contract to Audit Accounts".
(See Section VIII.K.)

10. Focused reviews of compliance with conflict of interest requirements of the CRAs for the East and Middle Tennessee Grand Regions had not been performed as of the last day of examination field work.
(See Section VIII.L.)

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, UPRV is required to file annual and quarterly NAIC financial statements in accordance with NAIC guidelines with the Tennessee Department of Commerce and Insurance. The department uses the information filed on these reports to determine if UPRV meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of

accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash, if necessary, to pay outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

At June 30, 2007, UPRV reported $397,553,879 in admitted assets, $203,080,010 in liabilities and $194,473,869 in capital and surplus on the 2007 NAIC Second Quarterly Statement submitted August 16, 2007. UPRV reported total net income of $29,668,002 on the statement of revenue and expenses.

1. Capital and Surplus

Tenn. Code Ann. § 56-32-212(a)(2) requires UPRV to establish and maintain a minimum net worth equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150 million of annual premium revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of $150 million for the prior calendar year.

Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions of the federal Social Security Act (title XIX), and regulations promulgated pursuant thereto, or pursuant to any other federal law as adopted by amendment to the required title XIX state plan..." Based on this definition, all TennCare payments made to an HMO licensed in Tennessee are to be included in the calculation of net worth and deposit requirements, regardless of the reporting requirements for the NAIC statements.

Effective April 1, 2007, UPRV executed an additional contract with the TennCare Bureau for expansion into the Middle Tennessee Grand Region. Section 2.21.5.2.2 of the Middle Contractor Risk Agreement requires that the calculation of minimum net worth shall be based upon annual projected premiums including the estimated premiums for the additional enrollment versus the prior year actual premium revenue. Estimated premiums will be based on the capitation payment rates in effect at the time of the calculation and projected future enrollment.

2007 Statutory Net Worth Calculation

At June 30, 2007, UPRV has reported capital and surplus totaling $194,473,869. UPRV reported nationwide premiums per the 2006 NAIC Annual Statement of $735,716,060. UPRV received $170,245,984 in ASO payments from the TennCare Bureau for the East Tennessee Grand Region during calendar year 2006. The TennCare Bureau provided TDCI on February 12, 2007, an estimate for the projected Middle Tennessee Grand Region expansion revenue of $458,500,031. Therefore, the 2007 minimum statutory net worth requirement, effective April 1, 2007, is $24,216,931 [$150,000,000 x 4% + (($735,716,060 + $170,245,984 + $458,500,031) - $150,000,000) x 1.5%]. UPRV's reported net

worth at June 30, 2007, was $170,256,938 in excess of the minimum required.

TennCare Premium Revenue for the Examination Period

For the examination period January 1 through June 30, 2007, the following is a summary of UPRV's premium revenue from TennCare operations as defined by Tenn. Code Ann. § 56-32-212(a)(2):

East Tennessee Grand Region		
Administrative fee payments from TennCare for the period January 1 through June 30, 2007	$5,613,249	
Reimbursement for medical payments from TennCare for the period January 1 through June 30, 2007	82,931,334	
Reimbursement for premium tax payments from TennCare for the period January 1 through June 30, 2007	1,677,737	
Total East Tennessee premiums for the period January 1 through June 30, 2007		$90,222,320
Middle Tennessee Grand Region		
Total Middle Tennessee premiums for the period April 1 through June 30, 2007		120,906,892
Total TennCare Premiums		
Total premiums for TennCare operations for the period January 1 through June 30, 2007		$211,129,212

2. Restricted Deposit

Beginning July 1, 2005, an amendment to the non-risk CRA for the East Tennessee Grand Region required MCOs to have on deposit an amount equal to the calculated statutory minimum net worth requirement. The risk contract for the Middle Tennessee Grand Region effective April 1, 2007, has similar provisions. In addition Section 2.21.5.4 for Middle Tennessee states:

TDCI shall calculate the amount of the increased restricted deposits based on the CONTRACTOR's TennCare premium revenue only unless this calculation would result in restricted deposits below the statutory requirements set forth in TCA 56-32-212 related to restricted deposits; in which case the required amount would be equal to the statutory requirement as it is calculated by TDCI.

Utilizing only TennCare premiums, the calculation does not result in a restricted deposit below the statutory requirements set forth in Tenn. Code Ann. § 56-32-212. The total TennCare premiums utilized in the deposit calculation included $170,245,984 for the East Tennessee Grand Region for 2006 and $458,500,031 for estimated premiums in Middle Tennessee Grand Region for 2007. Based upon TennCare premium revenues of $628,746,015, UPRV's statutory deposit requirement at April 1, 2007, was $13,181,190. UPRV had on file with TDCI the necessary safekeeping receipts documenting that deposits totaling $14,500,000 had been pledged for the protection of the enrollees in the State of Tennessee.

3. Claims Payable

As of June 30, 2007, UPRV reported $142,703,178 claims unpaid on the 2007 NAIC Second Quarterly Statement. Of the total claims unpaid, $71,687,432 represents an estimate for the Middle Tennessee Grand Region at-risk operations for TennCare for the period April 1, 2007 through June 30, 2007. This amount was certified by a separate statement of actuarial opinion. None of the reported $142,703,178 total claims unpaid represents an estimate for East Tennessee Grand Region non-risk operations for TennCare. UPRV has provided a separate actuarial comfort letter for estimates of unpaid claims of $26,933,330 for East Tennessee Grand Region non-risk operations for the period ending June 30, 2007. Review of the triangle lag payment reports after June 30, 2007, through November 30, 2007, for dates of services before July 1, 2007, determined that the reported claims payable for TennCare operations in the East and Middle Tennessee Grand Regions appears reasonable.

B. TennCare Operating Statements

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

As previously mentioned, the CRA for the East Tennessee Grand Region between UPRV and the State of Tennessee does not currently hold UPRV 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, ASO lines of business have no liability for future claim payments; thus, no provisions for IBNR are reflected on the balance sheet.

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

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

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

UPRV earned additional funds from the bonus pool of $892,350.49 for the period July 1, 2006 through June 30, 2007 for favorable performance related to risk initiatives.

Although UPRV is under an ASO arrangement as defined by NAIC guidelines, the CRA for the East Tennessee Grand Region 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 operations for UPRV in the East Tennessee Grand Region were still operating at-risk. As stated in Section 2-10.h.2. of the CRA, UPRV 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 deficiencies were noted in the preparation of the TennCare operating statement for the East Tennessee Grand Region:

- UPRV reported $85,736,072 premium revenue for the non-risk East Tennessee Grand Region. This does not agree to the total of all payments received from the TennCare Bureau for the period January 1, 2007 through

June 30, 2007 of $90,222,320.

- The amount reported as investment income is based on an allocation derived from the administrative revenue received from the TennCare Bureau compared to total company premiums. This method of allocation for reporting investment income does not appear reasonable. UPRV should develop a method that is based upon interest earned on funds held for investment for TennCare operations.

Management Comments

- Management concurs. The UPRV reported premium revenue for the non-risk East Tennessee Grand Region does not agree to the total of all payments received from the TennCare Bureau for the audit period as the 2A was prepared on an incurred basis (accounting month) versus a cash basis, which has now been requested by the TDCI. As such, UPRV will adjust its process to reflect cash basis reporting. The 2A for December 2007 was converted to a cash basis to tie to cash received per the premium tax calculation.

- Management concurs. The amount reported as investment income is based on an allocation method derived from the administrative revenue received from the TennCare Bureau compared to total company premiums. Per the TennCare on-site audit, UPRV will no longer report this amount on the East Tennessee Grand Region report 2A until a specific method is agreed to by TDCI, and UPRV.

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

Sections 2.30.14.3.3 and 2.30.14.3.4 of the CRA for the Middle Tennessee Grand Region require each submission of NAIC financial statements to contain a separate income statement detailing the quarterly and year-to-date revenues earned and expenses incurred as a result of participation in the TennCare program.

The following deficiencies were noted in the preparation of the TennCare operating statement for the Middle Tennessee Grand Region:

- The amount reported as investment income is based on a previously budgeted amount for pro forma income statements submitted to the TennCare Bureau as a requirement for the significant expansion into Middle Tennessee. This method of allocation for reporting investment income does not appear reasonable. UPRV should develop a method that is based upon interest earned on funds held for investment for TennCare operations.

- Expenses paid to UBH for the administration of behavioral health services were incorrectly excluded from administrative expenses.

Management Comments

- Management concurs. The amount reported as investment income is based on an allocation method derived from the administrative revenue received from the TennCare Bureau compared to total company premiums. As requested by the on-site TennCare examiner, UPRV will no longer report this amount on the Middle Tennessee Grand Region report 2A and look forward to working with TDCI to develop an acceptable method.

- Management concurs. Expenses paid to UBH for the administration of behavioral health services were incorrectly excluded from administrative expense and UPRV will correct going forward. For the December 2007 filing expenses were included in the 2A.

C. Medical Services Monitoring

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

No discrepancies were noted during the review of documentation supporting the amounts reported on the Medical Services Monitoring Report.

D. Medical Loss Ratio Report

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

> The CONTRACTOR shall submit a *Medical Loss Ratio Report* monthly with cumulative year to date calculation using the forms in Attachment IX, Exhibit N. The CONTRACTOR shall report all medical expenses and complete the supporting claims lag tables. This report shall be accompanied by a letter from an actuary, who may be an employee of the CONTRACTOR, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy. The CONTRACTOR shall also file this report with its NAIC filings due in March and September of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report

must reconcile to NAIC filings including the supplemental TennCare income statement.

The medical loss ratio report as submitted for the period April 1, 2007 through June 30, 2007, originally reported a medical loss ratio of 94.25%. Administrative fees are approximately 10% and premium taxes are 2% of total premiums. In order for UPRV to break even the MLR should be 88%. TDCI is concerned with the reported MLR percentage and therefore, monitors monthly the changes to this percentage. Because of the significant excess net worth previously discussed, TDCI has not taken any other regulatory action at this time. A review of the MLR report submitted for December 2007 indicates a decreased MLR percentage of 91% for the expanded period April 1, 2007 through September 30 2007.

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

E. Schedule of Examination Adjustments to Capital and Surplus

As result of the examination procedures for the limited review of TennCare operations, no adjustments are recommended to Capital and Surplus for the period ending June 30, 2007.

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. § 56-32-226(b)(1) and Section 2-18. of the CRA for the East Tennessee Grand Region and Section 2.22.4 of the CRA for the Middle Tennessee Grand Region. 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. § 56-32-226(b)(1) by testing in three-month increments data file submissions from each of the TennCare MCOs. Each month is tested in its entirety for compliance with the prompt pay requirement of Tenn. Code Ann. If a TennCare MCO fails to meet the prompt pay standards in any of the three months tested, TDCI, at a minimum, requires claims data submissions on a monthly basis for the next three months to ensure the MCO remains compliant.

During fieldwork, it was determined that UPRV had not submitted to TDCI prompt pay data files for claims processed by all subcontractors. Davis Vision processes vision claims for UPRV in the East Tennessee Grand Region, but the original data file submissions to TDCI did not include claims processed by Davis Vision. After fieldwork, UPRV submitted data files for the subcontractor from January 2007 through the current period. Testing revealed that Davis Vision was in compliance with §56-32-226(b)(1). TDCI recalculated prompt pay percentage for East Tennessee. See results of the recalculated prompt pay testing below.

Management Comments

- Management concurs. All claims processed on behalf of TennCare members will be included in each Prompt Pay submission, including those processed by vision subcontractors Davis Vision in the East Tennessee Grand Region, and Spectera in the Middle Tennessee Grand Region. As noted in the report, data for the year 2007 has been submitted, and ongoing submissions in 2008 have continued to include all claims processing activities.

The prompt pay testing results for the examination period, as well as through current testing by TDCI, are presented for East Tennessee Grand Region, Middle Tennessee Grand Region and combined. The results include claims processed by subcontractors for vision claims.

East Tennessee Grand Region	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2007	99%	100.0%	**Yes**
February 2007	99%	100.0%	**Yes**
March 2007	99%	100.0%	**Yes**
April 2007	99%	100.0%	**Yes**
May 2007	99%	100.0%	**Yes**
June 2007	99%	99.9%	**Yes**
July 2007	94%	99.9%	**Yes**
August 2007	98%	99.7%	**Yes**
September 2007	97%	99.8%	**Yes**
October 2007	99%	99.9%	**Yes**
November 2007	99%	99.9%	**Yes**

Middle Tennessee Grand Region (effective April 1, 2007)	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
April 2007	99%	100.0%	**Yes**
May 2007	100%	100.0%	**Yes**
June 2007	99%	100.0%	**Yes**
July 2007	93%	99.9%	**Yes**
August 2007	98%	99.9%	**Yes**
September 2007	99%	99.9%	**Yes**
October 2007	99%	99.9%	**Yes**
November 2007	99%	99.8%	**Yes**

UPRV Combined for TennCare Operations	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2007	99%	100.0%	**Yes**
February 2007	99%	100.0%	**Yes**
March 2007	99%	100.0%	**Yes**
April 2007	99%	100.0%	**Yes**
May 2007	99%	100.0%	**Yes**
June 2007	99%	100.0%	**Yes**
July 2007	93%	99.9%	**Yes**
August 2007	98%	99.8%	**Yes**
September 2007	99%	99.9%	**Yes**
October 2007	99%	99.9%	**Yes**
November 2007	99%	99.9%	**Yes**

For TennCare operations, UPRV processed claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for the months January through November 2007.

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

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

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

- Prior examination findings related to claims processing,
- Complaints or independent reviews on file with TDCI related to inaccurate claims processing,
- Results of prompt pay testing by TDCI,
- Results reported on the claims payment accuracy reports submitted to TDCI and the TennCare Bureau,
- Review of the preparation of the claims payment accuracy reports,
- Review of internal controls related to claims processing, and
- Follow-up to the claims processing readiness review for the Middle Tennessee Grand Region which began operations April 1, 2007.

As noted below, TDCI discovered deficiencies related to UPRV's procedures for preparing the claims payment accuracy reports. Additional testing was performed as

a follow-up to TDCI's claims processing readiness review for the Middle Tennessee Grand Region. A discussion of the additional testing and results of the follow-up can be found in Section VII.C. of this report. The standard claims sample size of 60 claims was selected for testing in the East Tennessee Grand Region while an expanded sample size of 129 claims was selected for testing in the Middle Tennessee Grand Region. A discussion of the sample selection methodology can be found in Section VII.E. of this report.

C. Follow-up to the Claims Processing Readiness Review of the Implementation of the Middle Tennessee Grand Region Operations

UPRV was awarded a TennCare contract for the Middle Tennessee Grand Region to begin April 1, 2007. As part of the approval process by TDCI for the significant expansion, TDCI performed an implementation readiness review with a site visit to UPRV offices on February 28, 2007. Issues discovered during the review included:

1. Community Mental Health Centers (CMHC)

   UPRV is currently testing the claims processing procedures related to CMHC claims. Two of five contracts have been executed and none have been loaded into the claims processing system as of the date of the readiness review site visit.

   > Follow up testing October 16, 2007: UPRV has executed and loaded six CMHC contracts.

2. Testing Documentation

   UPRV relied on the configuration for the TennCare product in East Tennessee for physical health services configuration in Middle Tennessee. For the mental health configuration, UPRV built upon experience processing mental health claims for UBH from other lines of business. Processing of behavioral health claims is based upon a complex reimbursement methodology.

   > Follow up testing October 16, 2007: see discussion below regarding processing of CMHC claims.

3. CRG\TPG Assessment Load Processes

   UPRV demonstrated significant progress in this area. UPRV has contacted most CMHCs and the State RMHIs for submission and testing.

   > Follow up October 16, 2007: no significant items noted.

4. Contingency Plan for Behavioral Health Claims

   Behavioral health claims will be processed by four examiners in the Waterloo office. These individuals are experienced in processing UBH claims.

Follow up testing October 16, 2007: see discussion below regarding the processing of CHMC claims.

Before the current fieldwork, UPRV provided a post implementation issues log. The log provides UPRV a tool for ensuring that issues related to the Middle Tennessee implementation are resolved timely. The log documents priority, issue name and description, individual assigned, comments, action, open/closed/completed dates for each issue logged. Responsible parties or team members involved with this log include a management team representing Claims, Customer Service and Tennessee Operations. Other individuals are invited to meetings to discuss the log as needed. The Vice President of Operations for Tennessee is designated as the team leader. The frequency of meetings to discuss the issue log is as follows:

Issues Other than Behavioral Health:

March 2007 through May 2007	Daily
June 2007	3 Times Weekly
July 2007 to Current	1 Time Per Week

Issues related to Behavioral Health:

March 2007 through August 2007	Daily
September 2007	2 Times Weekly
Currently	1 Time Per Week

Issues to be included on the log arise from several sources including issues noted by the call center, the contracting team or by claims examiners. UPRV's criterion for inclusion of an issue on the log includes:

- Significant change in processing rules for claims,
- Claim backlogs require follow up in other areas such as provider education/provider loading,
- Impact on Customer Service call volumes, and
- Process broken where impact causes claims backlogs.

Since UPRV was already serving the East Tennessee Grand Region, the number of implementation issues was significantly reduced because of the familiarity with the TennCare product. UPRV notes the issues specific to the implementation in Middle Tennessee included:

- the addition of behavioral health services,
- the grace period of 90 days allowed for continuity of care, and

- the requirement for processing of claims related to retroactive eligibility prior to the implementation date of April 1, 2007.

Other problems noted with the Middle Tennessee implementation were due to provider education and adherence to AmeriChoice's policies and procedures. When issues identified on the log require the reprocessing of claims, a separate log of reprocessing projects is maintained. The adjustments are initiated by a Claim Adjustment Request Form (CARF).

As of October 8, 2007, the log reported only three open issues from a total of 20 issues. The open issues include:

- "Auths not matching" – A separate system maintains authorizations from the claims processing system. Notes from the authorization system are not transferred to the claims system. Additionally, authorizations have not been loaded or are mismatched that require claims to be pended. UPRV's stated corrective action is a change in internal processes, daily monitoring, and testing of the matching process.

- "CMHCs holding claims" – Claims submission levels for some CMHCs are not at expected levels. UPRV's stated corrective action is provider education of the importance of submitted encounter data

- "Inappropriate billing by BH providers" – Behavioral providers are billing procedure codes not in their executed contracts. This results in a significant number of "close-outs" or denials of claims. UPRV's stated corrective action is further provider education.

A discussion of some of the more significant issues deemed closed by UPRV include:

- An enrollee can obtain TennCare eligibility retroactive to before the start date of the plan, April 1, 2007. UPRV has been contracted by the Bureau to process claims with dates of service prior to April 1, 2007, and TennCare will reimburse the plan for the medical cost of these claims plus pay an administrative fee for the processing of the claim. UPRV has developed additional manual processing steps to verify retroactive eligibility loaded from TennCare. Claims may require a reprocessing project where the provider has submitted the claim prior to TennCare notifying UPRV of the retroactive eligibility. Claims involving retroactive eligibility selected for testing during the examination found the additional processes to be satisfactory with the exception of one claim. The claim incorrectly denied for timely filing, because of a claims examiner error in recognizing a retroactive enrollee's eligibility.

- For continuity of care, UPRV overrode authorization and non-participating provider requirements for the first 90 days of the plan beginning April 1, 2007. Non-participating providers were paid at 100% of the lowest participating

provider's fee schedule with the exception of emergency room services. As to be expected, UPRV noted that the transition was not smooth for providers that remained non-participating after the 90 days. The non-participating providers continued to expect claims to be paid without authorization and at 100% of the lowest participating provider fee schedule.

- Private duty nursing services are typically not a Medicare covered benefit. UPRV does require a prior authorization for private duty nursing services. For TennCare enrollees with both Medicare and Medicaid coverage, UPRV initially denied private duty nursing services for these enrollees requesting a denial first from Medicare. Providers had not been under the same requirement by the previous MCOs for Middle Tennessee, resulting in complaints about the administrative burden of the policy that would only result in a delay of payment. On August 13, 2007, UPRV modified business rules to allow claims to be processed without the provider first submitting a denial by Medicare. UPRV noted that the volume of private duty nursing services in Middle Tennessee was higher than expected. For operations in East Tennessee before the Middle Tennessee operations began, care managers would note that the requirement for a Medicare denial should be overridden as the authorization was granted. This issue caused UPRV to reprocess approximately 500 claims.

Other Issues Discussed With the Plan:

Community Mental Health Centers

As noted from results of the readiness review on February 28, 2007, testing and configuration for the payment of CMHC claims was not completed before implementation. UPRV had demonstrated a contingency plan to process behavioral health claims after April 1, 2007. UPRV indicates that the contingency plan was not utilized since CMHCs delayed submission of claims. While configuration and testing was completed for the processing of CMHC claims, UPRV was able to manually process CMHC claims and work through any backlog. Most CMHCs are paid a case rate for services to the priority population. A case rate is paid once every 30 days based upon a specific procedure code billed by the CMHC. All other related procedures billed in the next 30 days are considered paid under the case rate payment. UPRV indicates that testing is nearly complete so that CMHC claims will auto adjudicate.

One advance payment was made to a CMHC. The CEO for UPRV for TennCare operations indicated that the advance was requested by the CMHC to ensure a level of cash flow and not related to problems in implementation of the claims system. The advance was secured through a promissory note agreement. UPRV failed to submit the agreement as a material modification of UPRV's certificate of authority pursuant to Tenn. Code Ann. § 56-32-203 (See Section VIII.C. of this report).

UPRV demonstrated online examples of the processing of case rate claims. The claims system is configured to pay the first submission of specific procedure codes for case rate payment every 30 days. Any claim that is submitted between payments is pended by the claims processing system as a procedure covered under the case rate payment. An examiner will manually override the pended claim with the following explanation code: “Previously Paid – May Be in Previous Payment”. UPRV is currently testing configurations that will automatically override the pended claim.

One CMHC provider is paid a flat monthly rate for both priority and non-priority members so a case rate calculation is not necessary. UPRV processes this provider’s submitted claims through all normal processes, except that no additional payment is required by the claims system. The same explanation code above will be reported back to the provider.

CMHCs claims tested by TDCI found instances where claims were denied as Medicare primary. (See Section VII.G.) The services are not covered by Medicare. UPRV changed their policies and procedures to override the request for Medicare explanation of benefits. UPRV indicated that 29 claims were reprocessed for this issue.

Transportation

East Tennessee Human Resource Agency (ETHRA) is subcontracted on a capitated basis to provide most non-emergent transportation services in Middle Tennessee. Monitoring procedures of this subcontractor by UPRV include review of daily call statistics, review of timely authorizations, random audit of the subcontractor’s call center, and the performance of an annual audit. UPRV noted that the EDI encounter submissions by ETHRA would be current by the week ending October 19, 2007.

Claims testing found issues during implementation with the payment of emergency claims to ambulance providers. The contracts for ambulance providers were only for non-emergent transportation services. UPRV’s intention was to pay ambulance providers at specific non-par rates for emergency services. During the first months of the plan, UPRV incorrectly processed emergency ambulance claims since no fees were loaded in the claims processing system. The contracts were only set up for non-emergency services. UPRV’s claims examiners should have selected the established non- par rates for emergency services instead of incorrectly paying $0 for trip charges and $0.01 for each mile. Testing of the adjusted claims found instances where the emergency transportation claims were reprocessed to pay at the emergency transportation non-par rates. (See Section VII.H) This issue required UPRV to reprocess 924 claims.

Regional Mental Health Institutes (RMHIs)

Discussion with UPRV personnel indicated they did not know of any outstanding issues related to the processing of RMHI claims.

Health Departments

Some of the issues involving the processing of health department claims included:

- The health departments provide services through many individual practitioners and it is a challenge to ensure credentialing of these practitioners,

- Issues have been found where the health departments' claims submissions incorrectly utilize a non-par provider number, and

- The health department's claims are not submitted electronically.

Summary of Post Implementation Review

The review of the implementation of the Middle Tennessee TennCare product on April 1, 2007, finds the problems encountered did not materially impact accuracy and timeliness of claims processing. As issues were discovered for a particular claim or provider type, UPRV utilized a post implementation issues log to ensure the problems were recognized and corrected. The auto adjudication rate for all claims reported by UPRV is 52.9% of all Middle Tennessee TennCare claims since April 1, 2007. This rate is not significantly different than that of the ongoing operations in East Tennessee at 60.7%. UPRV should continue to work through the remaining issues on the post implementation issues log.

Management Comments

- "Auths not matching" - Staff have been trained on correct loading of claims payment notes into the authorization system in order to accurately cross over into the claims system. Additionally, a Medical Review Unit is operational where they daily review high dollar claims where an auth is not loaded or where a mismatched auth is found by the processor. This process is operational.

- "CHMC Holding claims" - CMHCs are now submitting claims at expected levels.

- "Inappropriate billing by BH providers" - Behavioral Health providers have been educated on their contracts and are now correctly billing.

D. Claims Payment Accuracy Reports

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

UPRV for the East Tennessee Grand Region reported the following results for the first and second quarters of 2007:

East Tennessee	Results Reported	Compliance
First Quarter 2007	98.0%	**Yes**
Second Quarter 2007	99.7%	**Yes**

UPRV for the Middle Tennessee Grand Region reported the following results for the second quarter of 2007:

Middle Tennessee	Results Reported	Compliance
Second Quarter 2007	99.7%	**Yes**

During the examination period, UPRV was in compliance with claims payment accuracy requirements for East and Middle Tennessee CRAs.

1. Procedures to Review the Claims Payment Accuracy Reports

   The review of the claims payment accuracy reports included an interview with 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 UPRV agreed to requirements of Section 2-9.m.2. of the CRA for the East Tennessee Grand Region and Section 2.22.6.4 of the CRA for the Middle Tennessee Grand Region. These interviews were followed by a review of the supporting documentation used to prepare the 2007 second quarter reports for East and Middle Tennessee. Five claims from the East and five claims from the Middle samples reported as errors by UPRV were selected for verification by TDCI. Ten claims from the East and ten claims from the Middle samples reported as accurately processed by UPRV 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 UPRV, TDCI tested these claims to the attributes required in Section 2-9.m.2. of the CRA for the East Tennessee Grand Region and Section 2.22.6.4 of the CRA for the Middle Tennessee Grand Region.

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

   For the claims selected for verification by TDCI, ten claims reported as errors and the 20 claims reported as accurately processed, TDCI agrees with the results

reported by UPRV. However, the following deficiencies were noted during the review of the procedures to prepare claims payment accuracy reports.

- In determining claims payment accuracy percentages reported to the TennCare Bureau, UPRV failed to include vision claims processed by their subcontractors in both the East Tennessee Grand Region and the Middle Tennessee Grand Region. When selecting claims for determining the claims payment accuracy percentages, the subcontractors' claims should be included and the test work should be performed by UPRV.

- Section 2-9.m.2. of the CRA for the East Tennessee Grand Region and Section 2.22.6.2 of the CRA for the Middle Tennessee Grand Region require the claims payment accuracy reports be prepared by the plan's Internal Audit Department. The reports are not prepared by UPRV's Internal Audit Department but rather by a Quality Assurance Unit within UPRV's Claims Operations Department. Initial resolution between the Claims Department staff and Quality Assurance staff in Moline, Illinois does not involve input from staff based in Tennessee.

- When testing claims for claims payment accuracy, the CRA requires the plan to compare payments to the contracted rate. UPRV did not test to the contracted rate for all claims selected.

- When testing claims for claims payment accuracy, the CRA requires the plan to determine if the member's eligibility at processing date was correctly applied. UPRV's procedure for this attribute was only to verify the social security number.

Management Comments

- Claim payment accuracy oversight of subcontracted vendor audit processes is accomplished through the Compliance Committee structure. Both vision subcontractors are refining claims payment accuracy testing according to UPRV requirements, and required changes will be implemented and reported via the existing oversight mechanisms in second quarter 2008.

- Management believes that our current process meets the contractual requirements. The claims payment accuracy function is performed by the Claims Quality Assurance team in Moline, Illinois. The Claims Quality team reports to Pam Blomgren, Manager Claims Quality. The UPRV claims team reports to Lynn Ripple, Director Claims. Both the claim and the quality teams report independently up to the CEO of the Operations Division.

  The Claims Payment Accuracy Reports are prepared and reviewed by the Quality Management team. The Quality Management team is accountable for reviewing the report and identifying any issues that need resolution. Minor, routine issues such as additional training recommendations, etc. are resolved between Quality Management and Claims. However the quarterly Claims

Payment Accuracy reports, as well as any significant findings, are reviewed by the AmeriChoice TN (ACTN) operational committee. That committee is chaired by AmeriChoice Vice President of Operations Heidi Kemmer and significant findings in the audit are reviewed, discussed, and addressed.

Moving forward, our Compliance and Internal Audit department will be responsible for these quarterly claims payment accuracy reports and will own submission of these reports to the state. The health plan Compliance Committee will also review these reports and any significant findings in those reports. The Compliance Committee will report to the UPRV Board any significant findings of the quarterly Claims Payment Accuracy Reports.

- Management believes we are in compliance with the testing requirements. When testing claims for claims payment accuracy, the CRA requires the plan to compare payments to the contracted rate. The Claims Quality department audits the claim payment accuracy of the examiner by performing several different audits each month. When verifying if the payment is correct, Quality will verify all manual calculations are performed correctly (if applicable) according to provider notes and business rules that the examiners have access to; otherwise, the fee loaded into the system is the payment amount allowed.

  Specifically in reference to 2.22.1.2.5; 1) The contract accuracy is audited at the contract entry level at the point of contract loading and 2) The contract accuracy in relation to final claim payment disbursement is audited at the point of claim payment as part of the transaction quality program. This ensures that the contractual rates and terms are accurately loaded in the claims payment system.

  The provider contract audit performed at the point of contract loading verifies the accuracy of the input of the contract content (contracted rates, fee schedule accuracy, alignment to correct fee schedules, etc).

  The transaction quality program performed at the point of claim payment verifies the accuracy of the payment system (Facets) and the processor application of contract wording in relation to the loaded provider contract.

  The accuracy of the auto adjudicated claims to the provider contract load is verified for each auto adjudicated claim.

  In addition, the accuracy of any manually processed claim is assessed for the accurate payment in relations to the provider contract. Areas assessed for accuracy include the selection of correct provider, application of INN vs. OON accuracy, demographics of the provider as well as the correct application of the contracted rate (fee schedule, contracted rates, special processing instructions, DRG rates, etc).

This audit criteria (audit of initial system setup and secondary review of interaction of setup with claim payment systems and processor interpretation) is consistent with the approach utilized for the other areas outlined in 2.22.1.2 - specifically, appropriate application of authorizations, member eligibility, benefit setup, etc. Our end to end processes ensures that our claims are accurately paid and audited.

TDCI Rebuttal

For each claim tested, the claims payment accuracy attributes of Section 2-9.m.2. of the CRA for the East Tennessee Grand Region and Section 2.22.6.4 of the CRA for the Middle Tennessee Grand Region requires the plan to compare payments to the contracted rate. UPRV should have received approval from the TennCare Bureau for the deviation from contractual requirements.

- Management does not concur. When testing claims for claims payment accuracy, the CRA requires the plan to determine if the member's eligibility at processing date was correctly applied. Quality audits the claim payment accuracy of the examiner by performing several different audits during the course of the month. Part of the auditing process is to verify that the correct member in the system correlates to the correct member submitted from the provider. The Quality Department verifies the eligibility based on member notes and dates loaded into the system and ensures that the eligibility date applied to the claim is accurate. A separate unit within our enrollment department validates the accuracy of eligibility data within our claims system. Any enrollment transactions that cannot be processed automatically are directed to an error report which the enrollment coordinators investigate and correct within 3 business days. Enrollment coordinators initial and date the logs and give to auditor to review.

TDCI Rebuttal

For each claim tested, the claims payment accuracy attributes of Section 2-9.m.2. of the CRA for the East Tennessee Grand Region and Section 2.22.6.4 of the CRA for the Middle Tennessee Grand Region requires the plan to determine if the members eligibility a the processing date was correctly applied. UPRV should have received approval from the TennCare Bureau for the deviation from contractual requirements.

E. Claims Selected For Testing From Prompt Pay Data Files

For the East Tennessee Grand Region, 60 claims were selected for testing and for the Middle Tennessee Grand Region, 129 claims were selected for testing from the July 2007 prompt pay data files previously submitted to TDCI. The 60 claims tested for the East Tennessee Grand Region included five high dollar claims with the remaining 55 claims judgmentally selected from paid and denied claims. A

breakdown of the 129 claims judgmentally selected for the Middle Tennessee Grand Region included the following processing types:

- 20 claims with an adjusted claim status,
- 35 claims with a paid claim status, and
- 74 claims with a denied claim status.

For each claim processed, the data files included the date received, date paid, the amount paid, and if applicable, an explanation for denial of payment.

The number of claims selected for testing was not determined statistically. The results of testing are not intended to represent the percentage of compliance or non-compliance for the total population of claims processed by UPRV.

To ensure that the July 2007 data files included all claims processed in the month, the total amount paid per the data files was reconciled to the triangle lags within an acceptable level.

F. 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 UPRV's claims processing system. 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 were compared to the data elements entered into UPRV's claims processing system.

For the 60 claims selected for testing for the East Tennessee Grand Region, no discrepancies were noted.

For the 129 claims selected for testing for the Middle Tennessee Grand Region, no discrepancies were noted.

G. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected. For the 60 claims selected for testing for the East Tennessee Grand Region, no discrepancies were noted. For the 129 claims selected for testing for the Middle Tennessee Grand Region, the following discrepancies related to adjudication accuracy were noted.

- For eight of the adjusted claims selected for testing, UPRV denied the claims on initial processing based on the fact that the enrollee also had Medicare coverage. For all eight of the claims tested, the services were non-covered services by Medicare. UPRV made a policy change on August 13, 2007 to allow certain procedures that will never be covered by Medicare to be processed as primary

without waiting for a Medicare explanation of benefits. All eight claims have been reprocessed and paid accordingly.

- For five of the adjusted claims selected for testing, the claims processor selected the incorrect provider number and associated fee schedule on first processing. The claims have been reprocessed and paid using the correct fee schedule.

- Five of the denied claims tested were improperly denied due to manual processing errors because the claims processing policies and procedures were not correctly applied. UPRV agreed and will reprocess the claims to pay correctly.

- Three of the denied claims tested were denied with the explanation that the member was not eligible on the date of service; however, the three enrollees were actually retroactively eligible for TennCare before the start of operations, April 1, 2007. UPRV is contracted to manually process claims and reimburse providers for covered services incurred prior to April 1, 2007; however, UPRV will not be at risk for these services. UPRV agreed to reprocess all three claims.

- Six of the denied claims selected were properly denied; however, the explanation reason communicated to the provider did not adequately explain the reason the claim was denied. UPRV should review all denial reasons listed to ensure that they clearly communicate to the provider the actual reason the claim was denied. UPRV has agreed to consider changing the denial reasons to more descriptive explanations.

Management Comments

- Management concurs. A change was made in processing rules to no longer require a Medicare EOB for those services that are not covered by Medicare. This particular change was made for Private Duty Nursing.

- Management concurs. Claims are not reflected as errors on log. Claims were originally paid to the incorrect provider and subsequently adjusted.

- Management concurs. Policies and Procedures are in place but were not followed by the processors. Processors have been educated and claims have been reprocessed.

- Management does not fully concur. UPRV has identified two claims processed in error and these have been reprocessed. A clarification of the process has been put in place to verify retro eligibility prior to processing. Documentation was updated 8/21/07.

- Management concurs with TDCI concerning the need to review the denial reason codes. We are in the process of reviewing certain codes to consider a more descriptive explanation.

H. 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 60 claims selected for testing for the East Tennessee Grand Region, no pricing accuracy discrepancies were noted.

For the 129 claims selected for testing for the Middle Tennessee Grand Region, the following pricing accuracy discrepancies were noted.

- Seven of the adjusted claims tested for emergency ambulance services were incorrectly paid. The fee schedule associated with these claims was incorrectly configured to pay $0 for each trip charge and $0.01 per each mile instead of at the established non-participating rates. The claims have been reprocessed and paid using the correct fee schedule.

- Eight of the paid claims tested for one hospital incorrectly paid when the service was contracted to pay on the reimbursement methodology known as diagnosis related group (DRG). An external tool was utilized to price the DRG payment, but the external tool did not agree to the terms of the executed provider contract. UPRV further identified that the error affects approximately 70 claims in total and has agreed to reprocess all effected claims.

Management Comments

- Management concurs.

- Management concurs. All corrections to the outlier DRG tool were completed by 10/30/07 and 70 claims were adjusted on that date.

I. Copayment Testing

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

Because the 60 claims for the East Tennessee Grand Region and the 129 claims for the Middle Tennessee Grand Region selected for testing did not include any claims with copayments calculated, examiners expanded testing and reviewed the claims history for 2007 for three enrollees with copayment requirements. No discrepancies were noted in the review of these claims.

J. 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 UPRV to provide two remittance advices selected from claims tested to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers. No discrepancies were noted between the claims payment per the claims processing system and the related information communicated to the providers.

K. Analysis of Cancelled Checks

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

The examiners requested UPRV to provide two cancelled checks from claims tested. UPRV provided the cancelled checks. The check amounts agreed with the amounts paid per the remittance advice and no pattern of significant lag times between the issue date and the cleared date was noted. .

L. Pended and Unpaid Claims Testing

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

The pended and unpaid data files submitted to TDCI as of November 30, 2007, were reviewed for claims which exceeded 60 days old. The pended and unpaid data files for East and Middle Tennessee processed by UPRV, as well as the two subcontractors, indicate only 16 claims exceed 60 days in process. No material liability exists for claims over 60 days.

M. Electronic Claims Capability

Section 2-9.m.3. of the CRA for the East Tennessee Grand Region states, “The CONTRACTOR shall provide the capability of electronic billing.” Section 2.22.2.2 of the CRA for the Middle Tennessee Grand Region states, “The CONTRACTOR shall have in place, an electronic claims management (ECM) capability that accepts and processes claims submitted electronically...” The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II (HIPAA) requires that all health plans be able to transmit and accept all electronic transactions in compliance with certain standards as explained in the statute by October 15, 2002. The U.S. Department of Health and Human Services extended the deadline until

October 15, 2003, for health plans requesting additional time. Failure to comply with the standards defined for the transactions listed can result in the assessment of substantial penalties.

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

N. Mailroom and Claims Inventory Controls

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

UPRV provided the most recent report of USCRV prepared in accordance with Statement on Auditing Standards (SAS) No. 70, Service Organizations for the period November 1, 2005, through October 31, 2006. USCRV is the affiliated management company that processes medical claims for UPRV. No relevant exceptions were noted in the controls tested by the external auditor that provided reasonable assurance that valid claims are completely and accurately entered into the imaging and claims system.

The review of mailroom and claims inventory controls by TDCI included interviews with UPRV personnel and review of the mailroom and claims processing flowcharts. On a weekly basis, claims are randomly selected in the mailroom by UPRV personnel. The claims are photocopied and later the received date is verified with the date entered into the system. TDCI requested and UPRV provided the latest example of the UPRV audit. A physical inspection of the mailroom is completed twice a week by UPRV personnel to ensure claims have not been lost. Claims that cannot be entered into the claims processing system are returned to the provider with a form letter detailing the reason for rejection. An example of a claim that cannot be entered into the claims system is for an enrollee that was never eligible for UPRV's TennCare plans.

The mailroom operations in Moline, Illinois, were visited and reviewed during the previous TDCI examination. Based upon the results of the prior examination by TDCI, the most recent external SAS 70 review of claims operations, current procedures, interviews, and examples of UPRV's mailroom audits and inventory reports, UPRV ensures that all claims received from providers are either returned to the provider where appropriate or processed by the claims processing system.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints

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

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

Ten provider complaints were judgmentally selected from listings provided by UPRV. For the ten provider complaints tested, UPRV responded timely to the provider. No discrepancies were noted.

B. Provider Manual

The provider manual outlines written guidelines to providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim.

For the Middle Tennessee Grand Region, the provider manual for UPRV's TennCare operations and a separate provider manual for Spectera, Inc. was submitted and approved by TDCI.

For the East Tennessee Grand Region, the provider manual for UPRV's TennCare operations was submitted to TDCI in September 2006, but was disapproved. The provider manual was resubmitted in October 2007, but due to continuing deficiencies TDCI disapproved the manual. The plan is currently operating in the East Tennessee Grand Region with the unapproved provider manual. Additionally a separate provider manual for Davis Vision, Inc. has never been submitted to TDCI for approval. UPRV is required to file a notice and obtain the Commissioner's approval prior to any material modification their operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1).

Management Comments

Management concurs. UPRV has an updated East Tennessee Grand Region Provider Manual which addresses both the deficiencies noted in the October 2007 review and newly requested claims process changes. This updated Provider Manual will be filed by April 11, 2008. A separate provider manual for Davis Vision, Inc. will also be filed with TDCI for approval by May 2008.

C. Provider Agreements

Agreements between an HMO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO as provided by Tenn. Code Ann. § 56-32-203(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. § 56-32-203(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 2-9.f. of the CRA for the East Tennessee Grand Region and Section 2.12.2 of the CRA for the Middle Tennessee Grand Region between UPRV and the TennCare Bureau, all template provider agreements and revisions thereto must be approved in advance by TDCI, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Additionally, Section 2-18. of the CRA for the East Tennessee Grand Region and Section 2.12.7 of the CRA for the Middle Tennessee Grand Region report the minimum language requirements for provider agreements.

Four executed provider agreements for East Tennessee providers and six executed provider agreements for Middle Tennessee providers were judgmentally selected for testing from the provider network directory files submitted directly to the TennCare Bureau.

For three of the four provider agreements selected for testing for the East Tennessee Grand Region, the following deficiencies were noted.

- A hospital provider agreement was signed in October 2001. The agreement is deemed materially out of compliance with provider agreement language requirements of Section 2-18. of the CRA for the East Tennessee Grand Region since numerous language revisions have been required for provider agreements since 2001. UPRV did receive TDCI approval in February 2004 and September 2007 for an updated provider agreement template but UPRV did not amend the selected hospital provider agreement to agree with the approved template.

- An ancillary provider agreement was signed in December 2005 using a template approved as of September 2004. The agreement is deemed materially out of compliance with provider agreement language requirements of Section 2-18. of the CRA for the East Tennessee Grand Region since numerous language revisions have been required for provider agreements since September 2004.

- A unique ancillary provider agreement was executed in June 2004. This agreement has never been submitted to TDCI for approval as a material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). The agreement is deemed materially out of compliance with provider agreement language requirements of Section 2-18. of the CRA for the East Tennessee Grand Region since numerous language revisions have been required for provider agreements since June 2004.

For two of the six provider agreements selected for testing for the Middle Tennessee Grand Region, the following deficiencies were noted:

- A physician group provider agreement was signed in May 2001 to operate in the East Tennessee Grand Region. The provider operates in both the East and Middle Tennessee Grand Regions. The agreement is deemed materially out of compliance with provider agreement language requirements for Section 2-18. of the CRA for the East Tennessee Grand Region since numerous language revisions have been required for provider agreements since May 2001. This provider has not been contracted to provide services in the Middle Tennessee Grand Region, but UPRV has included this provider in its Middle Tennessee provider directory. UPRV was cautioned numerous times during the approval process for the expansion into the Middle Tennessee Grand Region that, if East Tennessee providers also provide services in the Middle Tennessee Grand Region, a separate provider agreement must be executed for each region.

- A CMHC is contracted through a prior approved provider agreement template; however, UPRV and the CMHC executed a separate promissory note agreement. The promissory note agreement was not submitted to TDCI for prior approval in violation of Tenn. Code Ann. § 56-32-203(c)(1). UPRV indicated the advance payment associated with the promissory note was not the result of any claims processing issues but rather was granted at the request of the CMHC to ensure a level of cash during the implementation of the Middle Tennessee Grand Region operations beginning April 1, 2007.

UPRV should review all provider agreements to determine if they meet the appropriate language requirements of either Section 2-18. of the CRA for the East Tennessee Grand Region or Section 2.12.7 of the CRA for the Middle Tennessee Grand Region. For providers that provide services in both the East and Middle Tennessee Grand Regions, provider agreements must be executed utilizing the most recently approved provider templates for both regions. UPRV should review statutory requirements of Tenn. Code. Ann. § 56-32-203 and appropriately file for prior approval any material modifications to UPRV's certificate of authority.

Management Comments

- Management concurs. UPRV has submitted and received approval for new provider templates, which have been approved for use in both Middle and East Tennessee Grand Regions. We are currently developing a strategy to recontract providers in the East and Middle Tennessee Grand Regions whose

contracts do not contain the currently required elements. This strategy will be finalized by May 2008.

D. Provider Payments

Capitation payments to providers were tested during 2007 to determine if UPRV complied with the payment provisions set forth in its capitated provider agreements. Review of payments to capitated providers indicated that all payments were made per the provider contract requirements in a timely manner.

E. Subcontracts

HMOs are required to file notice and obtain the Commissioner's approval prior to any material modification of operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). Additionally, Per Section 2-9. of the CRA for East Tennessee and 2.26.3 of the CRA for Middle Tennessee all template subcontractor agreements and revisions thereto must be approved in advance in writing by TDCI, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof.

The following deficiencies were identified in the subcontracts tested:

- One subcontract for the administration of vision services in the East Tennessee Grand Region, including credentialing services and the payment of vision claims, was prior approved by TDCI in October 2004.
  - The subcontractor contracts directly with providers of vision services. UPRV has not submitted the provider agreement between the subcontractor and vision providers for prior approval per Section 2-9. of the CRA for the East Tennessee Grand Region.
  - The vision subcontractor's provider manual has never been submitted to TDCI for approval in violation of Tenn. Code Ann. § 56-32-203(c)(1).
  - The contract was amended in November 2004 but the amendment was not submitted to TDCI for approval in violation of Tenn. Code Ann. § 56-32-203(c)(1) and Section 2-9. of the CRA for the East Tennessee Grand Region.
- An affiliated company provides subrogation recovery services in both the East and Middle Tennessee Grand Regions. A percentage fee is charged based on the amounts recovered. This fee paid to the affiliate reduces the amount applied as a recovery to each claim affected. No subcontract has been submitted to TDCI for prior approval which would allow the payment for these services to a related party. UPRV should submit for prior approval a subcontract defining the

services provided by the related party pursuant to Tenn. Code Ann. § 56-32-203(c)(1).

Management Comments

- Management concurs. The subcontract for the provision of vision services in East Tennessee between UPRV and Davis Vision will be submitted with updated amendments and required language to TDCI for approval. This submission will also include the Davis Vision direct provider contracts and the provider manual. These documents will be submitted by May 2008.
- Management concurs that no subcontract for subrogation services has been submitted. UPRV will be filing a subcontractor agreement that specifies these services provided by the affiliated company.

F. Non-discrimination

Section 2-24. of the CRA for the East Tennessee Grand Region and Section 2.28 of the CRA for the Middle Tennessee Grand Region require UPRV to demonstrate compliance with Federal and State regulations of Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age of Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981. Based on discussions with various UPRV staff and a review of policies and related supporting documentation, UPRV was in compliance with the reporting requirements of Section 2-24. of the CRA for the East Tennessee Grand Region and Section 2.28 of the CRA for the Middle Tennessee Grand Region.

G. Internal Audit Function

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

- As previously noted, Section 2-9.m.2. of the CRA for the East Tennessee Grand Region and Section 2.22.6.2 of the CRA for the Middle Tennessee Grand Region require the claims payment accuracy reports be prepared by the plan's Internal Audit Department. The reports are not prepared by UPRV's Internal Audit but rather by a Quality Assurance Unit within UPRV's Claims Operations Department.

- As of the last day of examination field work, focused reviews of compliance with the requirements of the CRAs for the East and Middle Tennessee Grand Regions had not been performed by Internal Audit. The Annual Audit plan submitted by UPRV to TennCare per Section 2-9.c.14. of the CRA for the East Tennessee Grand Region and Section 2.30.14.2.3 of the CRA for the Middle Tennessee Grand Region indicate an internal audit has been scheduled in January 2008. Corporate internal audit staff stated that the scope of the audit will cover areas outlined in the TennCare CRAs including testing of conflict of interest requirements.

- The Annual Audit Plan reported that the results of various audits performed will be reported to the Compliance Officer and the Chief Financial Officer at the Tennessee plan. The results of the various audits should also be presented timely to UPRV's board of directors.

Management's Comment

- Management believes that we have met the CRA requirements regarding internal audit preparation of the claims payment accuracy reports. UPRV's independent Claims Quality Assurance team is charged with overseeing, monitoring, and addressing claims payment issues within the UPRV claims payment function for all of the products on the FACETS platform. This role also includes, specifically for TennCare, preparing and responding to issues identified in the quarterly Claims Payment Accuracy reports. Minor and/or routine issues that could be addressed by additional staff training, etc. are immediately brought to the attention of the claims management staff for correction. More significant findings identified in the quarterly Claims Payment Accuracy reports are reported to the AmeriChoice TN (ACTN) operational committee and Vice President of Operations Heidi Kemmer.

  In the future, our Compliance and Internal Audit department will be responsible for these quarterly claims payment accuracy reports and will own submission of these reports to the state. The health plan Compliance Committee will also review these reports and any significant findings in those reports. The Compliance Committee will report to the UPRV Board any significant findings of the quarterly Claims Payment Accuracy Reports.

- Management concurs. As discussed with the auditors during their on-site review, the AmeriChoice TN/IA's TennCare operations were scheduled for a UnitedHealth Group internal audit during the first quarter. That internal audit has commenced and the field work on the first phase was completed in February. The field visit for the second phase, which included an on-site visit to our Knoxville office, is also complete. The scope of the internal audit includes Claims Quality and Accuracy, as well as TennCare Contract Compliance.

- Management concurs. The Annual Audit Plan for 2008 was recently submitted to TennCare. The 2008 Plan includes an overview of the numerous on-going audits that are conducted, including:

    - Financial auditing including internal controls, internal process and efficiency auditing
    - SOX compliance
    - Compliance auditing for adherence to laws and regulations
    - Claims auditing
    - Fraud, waste, and abuse auditing

  Audit results are reported to and reviewed by the plan Compliance Officer, Chief Financial Officer, and the health plan Compliance Committee. Internal audit results, as well as any other audit with significant findings will be reported to the UPRV Board of Directors.

H. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., Title 56, Chapter 11, Part 2 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-205 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner…." UPRV is domiciled in the State of Illinois and therefore the filing is regulated in Illinois. The review of the annual filing for Illinois is reviewed by TDCI for any discrepancies.

I. Behavioral Health Organization (BHO) Coordination

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

For the Middle Tennessee Grand Region, the CRA requires UPRV to provide both medical and behavioral health services. As previously mentioned, UPRV contracts with the affiliate, UBH, for the provision of behavioral health services.

J. Contractual Requirements for ASO Arrangements

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

1. Medical Management Policies

   Section 3-10.h.2(a) of Amendment 4 to UPRV's CRA for the East Tennessee Grand Region requires UPRV to comply with the following:

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

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

2. Provider Payments

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

   During test work of claims processed for the East Tennessee Grand Region, it was discovered that some providers have executed provider agreements that include a withhold provision. A withhold reduces the cash payment to the provider at the time of claims processing based upon an agreed-to percentage. Withhold percentages are typically 10% to 25%. The withhold reduction is accumulated in a separate pool of funds to be paid to the provider if UPRV's operations in a plan year are determined favorable. The withhold pool funds are maintained in an interest bearing account.

   When UPRV requests funding for medical claims processed in the East Tennessee Grand Region, it requests from the TennCare Bureau the cash to be paid at the time of processing plus any amounts of withholds computed. The request of the withhold is a violation of Section 3-10.h.2(b) of the CRA for the East Tennessee Grand Region, since the funds are not released to providers within 24 hours. The settlement of the return of withholds by UPRV could involve funds held for more than one year. UPRV should not request reimbursement for withholds until the withhold settlement has been computed and is ready to pay to the provider within 24 hours.

In addition, Section 3-10.h.2(d) of the CRA for the East Tennessee Grand Region states interest generated by funds on deposit for provider payments related to the non-risk agreement period shall be the property of the State. UPRV should remit to the TennCare Bureau all interest earned from all withholds held for TennCare operations for the East Tennessee Grand Region related to dates of service since July 1, 2002, the beginning of the non-risk operations.

Management Comments

Management does not concur; however, we intend to eliminate withhold as part of our 2008 provider re-contracting initiative.

TDCI Rebuttal

For funds held by UPRV for withhold purposes, UPRV has violated Section 3-10.h.2(b) and Section 3-10.h.2(d) of the CRA for the East Tennessee Grand Region.

3. 1099 Preparation

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

4. Interest Earned on State Funds

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

Funds related to outstanding checks for payments related to the non-risk agreement period are maintained in an interest bearing account. UPRV has failed to remit to the TennCare Bureau the interest earned on these funds in violation of Section 3-10.h.2(d) of the CRA for the East Tennessee Grand Region. UPRV should remit to the TennCare Bureau all interest earned for funds related to outstanding checks for the non-risk agreement period beginning July 1, 2002. This finding was previously noted in the prior examination by TDCI and remains uncorrected.

Management Comments

Management concurs with the finding, but does not agree with the recommendation that the plan should develop a methodology to calculate the interest generated from deposits of TennCare funds and remit these amounts to

the TennCare Bureau. UPRV generates checks weekly to reimburse providers for claims submitted. Each Tuesday checks are generated for the prior week's processed claims and then mailed. The TennCare Bureau is invoiced the following Monday and UPRV receives payment by the end of that week. This payment is almost two weeks post check processing. UPRV is providing payment to the providers prior to invoicing and receiving payment from the TennCare Bureau and accordingly, we disagree that interest is owed or can be calculated. In fact UPRV is providing the State the use of our money without an interest charge. UPRV believes strongly in providing prompt and efficient payment to providers for services rendered and that is why we provide payment prior to receiving funds from the TennCare Bureau. Changing this process would involve delaying payment to providers and require providers to receive and post multiple checks each week from UPRV since they currently receive only one check for all UPRV lines of business.

TDCI Rebuttal

UPRV does have funds related to outstanding checks for payments related to the non-risk agreement period are maintained in an interest bearing account. UPRV has violated Section 3-10.h.2(b) of the CRA for the East Tennessee Grand Region since interest earned on outstanding check amounts are not remitted to the TennCare Bureau.

5. Recovery Amounts/Third Party Liability

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

6. Pharmacy Rebates

Section 3-10.h.2(f) of the CRA for the East Tennessee Grand Region states that pharmacy rebates collected by UPRV shall be the property of the State. The contract for pharmacy related services ended June 30, 2003. During the previous exam, UPRV indicated no further amounts were expected for pharmacy rebates.

K. Contract to Audit Accounts

UPRV is required to submit annual audited financial statements by May 1 for the preceding calendar year. Section 2-10.h.4. of the CRA for the East Tennessee Grand Region and Section 2.21.10.2 of the CRA for the Middle Tennessee Grand

Region require such audits to be subject to prior approval of the Comptroller of the Treasury and to be submitted on the standard “Contract to Audit Accounts” agreement. The “Contract to Audit Accounts” between the Comptroller of the Treasury and the external auditor defines the standards for which the audits are to be performed. UPRV has not complied with this provision. UPRV should ensure that their external auditor properly executes the “Contract to Audit Accounts” before each engagement.

Management Comments

UPRV has been working with the Division of State Audit and the external auditor to finalize execution of the "Contract to Audit Accounts" since September of 2007. In addition to the "Contract to Audit Accounts", professional auditing standards require accountants to obtain a signed access letter from regulators and other parties requesting working papers. The external auditor has agreed to execute the Contract to Audit Accounts upon receipt of an access letter from any non-TDCI entities as required by model audit rules.

TDCI Rebuttal

UPRV is in violation of Section 2-10.h.4. of the CRA for the East Tennessee Grand Region and Section 2.21.10.2 of the CRA for the Middle Tennessee Grand Region. Contract to Audit Accounts have not been executed.

L. Conflict of Interest

Section 4-7. of the CRA for the East Tennessee Grand Region and Section 4.19 of the CRA for the Middle Tennessee Grand Region warrant that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to UPRV in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

Conflict of interest requirements of the 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 organizational structure of UPRV includes a compliance officer who reports to the CEO for TennCare operations.
- UPRV has written conflict of interest policies and procedures in place.
- The written policies and procedures outline steps to report violations.
- The policy indicates all business associates are to comply with UPRV's conflict policy.
- Employees complete conflict of interest certificates of compliance annually per the written policy and procedures.

As previously noted in the internal audit discussion above, as of the last day of examination field work, focused reviews of compliance with the requirements of the CRAs for the East and Middle Tennessee Grand Regions had not been performed. The Annual Audit plan submitted by UPRV to TennCare indicates an internal audit has been scheduled in January 2008. Corporate internal audit staff stated that the scope of the audit will include testing of CRA conflict of interest requirements.

Management Comments

- Management concurs. An internal audit of the AmeriChoice TN/IA's TennCare operations has commenced. In addition to the Claims Quality and Accuracy review, the internal audit covers TennCare Contract Compliance, including conflict of interest.

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