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Market Conduct Examination and Financial and Compliance Examination of TennCare Operations of Volunteer State Health Plan, Inc., Chattanooga, Tennessee for the Period January 1, 2021 through December 31, 2021

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STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE OVERSIGHT DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

and

FINANCIAL AND COMPLIANCE EXAMINATION

OF

THE TENNCARE OPERATIONS

OF

**Volunteer State Health Plan, Inc.
d/b/a BlueCare of Tennessee and
d/b/a TennCare Select**

CHATTANOOGA, TENNESSEE

**FOR THE PERIOD JANUARY 1, 2021
THROUGH DECEMBER 31, 2021**

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TO: Carter Lawrence, Commissioner
Tennessee Department of Commerce and Insurance

Stephen Smith, Deputy Commissioner
Tennessee Department of Finance and Administration, Division of TennCare

VIA: Toby Compton, Deputy Commissioner
Tennessee Department of Commerce and Insurance

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Office of the Comptroller of the Treasury
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CC: Jim Bryson, Commissioner
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DATE: March 16, 2023

The Financial and Compliance Examination and Market Conduct Examination of the TennCare Operations of Volunteer State Health Plan, Inc., Chattanooga, Tennessee, was completed September 9, 2022. The report of this examination is herein respectfully submitted.

I. FOREWORD

On February 10, 2022, the TennCare Oversight Division of the Tennessee Department of Commerce and Insurance (TDCI) notified representatives of Volunteer State Health Plan, Inc., (VSHP) of its intention to perform a Financial and Compliance Examination and Market Conduct Examination of VSHP's TennCare Operations. Remote fieldwork began on July 11, 2022, and ended on August 15, 2022. All document requests and the signed management representation letter were provided by September 12, 2022.

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

II. PURPOSE AND SCOPE

A. Authority

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

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

B. Areas Examined and Period Covered

The financial examination focused on selected balance sheet accounts and the TennCare income statement submitted with its National Association of Insurance Commissioners (NAIC) Annual Statement for the year ending December 31, 2021.

The current market conduct examination by TDCI and the Comptroller focused on the claims processing functions and performance for VSHP's TennCare operations. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.

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

C. Purpose and Objective

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

The objectives of the examination were to:

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

III. PROFILE

A. Administrative Organization

VSHP was incorporated under the laws of the State of Tennessee on July 11, 1996. VSHP is a wholly owned subsidiary of Southern Diversified Business Services, Inc. (SDBS) which is a wholly owned subsidiary of Blue Cross Blue Shield of Tennessee, Inc. (BCBST). BCBST performs certain administrative functions of VSHP through an administrative service agreement between VSHP and BCBST.

The officers and directors or trustees for VSHP as reported on the NAIC Annual Statement for the year ending December 31, 2021, were as follows:

Officers for VSHP

Amber Jeanine Cambron, President/CEO
Erbon Dennis Culver, Treasurer
Jill Anne Langston, Secretary
Mandy Holland Savage, Assistant Treasurer
Kristy Leanne White, Assistant Secretary

Other Officers for VSHP

Casey Lee Dungan, Vice President, Chief Financial Officer
Jeanne James, M.D., Vice President, Chief Medical Officer
Janice Stanek Maurizio, Vice President
Jeffrey Aaron Hocking, Actuary
Jason Patrick Lloyd, Vice President
Stephani Jennifer Ryan, Vice President
Robert Cyrus Huffman M.D., Vice President, Chief Population Health Officer
Francis Elizabeth Martini, Vice President
Patrick Timothy Sullivan, Vice President, Chief Operating Officer

Directors or Trustees for VSHP

Jason David Hickey, Chairperson
John Francis Giblin
Scott Christian Pierce

B. Brief Overview

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

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

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

As of December 31, 2021, TennCare Select had approximately 53,000 TennCare members statewide and BlueCare had approximately 608,000 TennCare members statewide. The TennCare benefits required to be provided by VSHP include:

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

Effective January 1, 2008, BCBST contracted with the State of Tennessee to administer medical services for the Cover Tennessee program which provides coverage for Tennesseans who had difficulties in accessing health insurance. BCBST contracted with VSHP through an administrative service agreement to provide medical management, outreach and education and other related services to the plans associated with Cover Tennessee. Effective January 1, 2016, BCBST assigned to VSHP the responsibility of the CoverKids portion of the contract to VSHP. CoverKids offers free health coverage for pregnant women and children who do not have insurance and who do not qualify for TennCare. Additionally, effective January 1, 2016, VSHP and BCBST entered into an administrative service agreement for BCBST to provide general administrative services for VSHP's responsibility for the CoverKids program. For the year ending December 31, 2021, VSHP had approximately 17,000 enrollees in the CoverKids program.

Effective March 1, 2010, the CRA between VSHP and the Division of TennCare was amended for the implementation of the CHOICES program. CHOICES is TennCare's program for long-term care services. Long-term care services include care in a nursing home and certain services to help a person remain at home or in the community. Home and Community Based Services (HCBS) are services that include help doing everyday activities that enrollees may no longer be able to do for themselves as they grow older or if they have a physical disability that prevents them from bathing, dressing, getting around their home, preparing meals, or doing household chores. As of December 31, 2021, VSHP had approximately 2,400 enrollees assigned to the CHOICES program.

Effective July 1, 2016, VSHP began offering services through the Employment and Community First CHOICES program. Employment and Community First CHOICES is a new program for people of all ages who have an intellectual or developmental

disability (I/DD). Services in the new program will help people with I/DD live as independently as possible at home or in the community, not in an institution. If the person lives at home with their family, the services help their family support them to become as independent as possible, work, and actively participate in their communities. Benefits include self-advocacy supports for the person and for their family. Residential services are also covered for adults who need them. For the year ending December 31, 2021, VSHP had approximately 2,400 enrollees in the Employment and Community First CHOICES program.

Effective January 1, 2021, VSHP administers the CoverKids program through an at-risk arrangement with TennCare. The Children's Health Insurance Program (CHIP) is a federally sponsored program that provides health insurance to uninsured children. In Tennessee, this program is called CoverKids and includes children under age 19 and eligible mothers of unborn children who do not qualify for TennCare but meet certain income limits. For the year ending December 31, 2021, VSHP had approximately 17,000 CoverKids enrollees in Tennessee.

In addition to TennCare operations, VSHP began offering a Median Advantage Dual Special Needs Plan (D-SNP) effective January 1, 2014. Under this program, premiums for Medicare and Medicaid dual eligible members are received from the Centers for Medicare and Medicaid Services and the Division of TennCare. As of December 31, 2021, VSHP reported Medicare enrollment of approximately 22,000 members.

C. Claims Processing Not Performed by VSHP

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

During the period under examination, VSHP arranges for the provision of supported housing services through contracts with Community Mental Health Centers (CMHCs) which have in turn subcontracted with individual supported housing providers.

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

IV. SUMMARY OF CURRENT FINDINGS

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

A. Financial Deficiencies

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

B. Claims Processing Deficiencies

1. The CRA requires VSHP to self-test the accuracy of claims processing based on claims selected by TDCI on a monthly basis. For the 1,475 claims tested for the calendar year 2021, VSHP reported at least one attribute error on 47 claims during focused claim testing.

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

2. During the review of focused claims testing results, TDCI noted five (5) additional claims processing deficiencies that resulted in the reprocessing of 314 claims with billed charges of \$9,325.43. Details of the additional deficiencies are described in this report.

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

3. For three of the five enrollees selected for copayment testing, VSHP failed to properly apply copayment requirements based on the enrollee's eligibility status.

(See Section VI.E. of this report)

C. Compliance Deficiencies

1. Four of the 19 provider reconsideration requests tested were not resolved within 60 days of receipt. No written agreement was executed between the providers and VSHP to allow additional time to resolve the complaints. Per Tenn. Code Ann. § 56-32-126(b)(2)(A), "the health maintenance organization's reconsideration decision shall be issued within sixty (60) calendar days after receipt of the reconsideration request, unless a longer time to completely respond is agreed upon in writing by the provider and the health maintenance organization."

(See Section VII.A of this report)

2. For one provider reconsideration request, the received date was incorrectly recorded on the provider complaint log. The received date stamped on the provider complaint did not match the received date on the provider complaint log.

(See Section VII.A of this report)

3. For 11 provider reconsideration requests, the resolution date was incorrectly recorded on the provider complaint log. The resolution date did not match the remittance date of the reprocessed claim or the date of the resolution letter was sent to the provider by VSHP.

(See Section VII.A of this report)

4. For 12 of the 19 provider reconsideration requests tested which were not resolved within 30 calendar days of receipt, VSHP failed to inform the provider in an acknowledgement letter that a decision would be made within 60 calendar days of receipt. VSHP's policies and procedures and Tennessee Code Annotated requires VSHP to respond to reconsideration requests within 30 calendar days of the receipt of the request.

(See Section VII.A of this report)

5. For three of the 19 provider reconsideration requests selected for testing, TDCI determined manual errors caused the claims to be incorrectly processed on initial submission.

(See Section VII.A of this report)

6. For 13 of the 20 provider complaints submitted to TDCI selected for testing, VSHP's claims appeal procedures failed to properly determine the claims had been incorrectly denied.

(See Section VII.B. of this report)

7. For three of the 5 independent reviews select for testing, the medical review standards applied by VSHP during reconsideration was different than the medical review standards applied after the claim was submitted to TDCI for independent review.

(See Section VII.C. of this report)

8. VSHP failed to submit a subcontract to TDCI and the Division of TennCare for prior approval as required by CRA A.2.26.3.

(See Section VII.G of this report)

V. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, VSHP is required to file annual and quarterly NAIC financial statements in accordance with NAIC guidelines with TDCI.

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

As of December 31, 2021, VSHP reported \$1,133,941,583 in admitted assets, \$499,307,519 in liabilities and \$634,634,064 in capital and surplus on the NAIC Annual Statement submitted March 1, 2022. VSHP reported total net income of \$138,575,975 on the statement of revenue and expenses. The 2021 NAIC Annual Statement and other financial reports submitted by VSHP can be found at <https://www.tn.gov/commerce/tenncare-oversight/reports/managed-care-organization-financial-reports>.

1. Capital and Surplus

a. Risk-Based Capital Requirements:

VSHP is required to comply with risk-based capital requirements for health organizations as codified in TCA § 56-46-201 et seq. VSHP has submitted a report of risk-based capital (RBC) levels as of December 31, 2021. The report calculates an estimated level of capital needs for financial stability depending upon the health entity’s risk profile based on instructions adopted by the NAIC. As of December 31, 2021, VSHP maintains an excess of capital over the amount produced by the Company Action Level Events calculations required by TCA § 56-46-203. Additionally, VSHP’s RBC report did not trigger a trend test as determined with trend test calculations included in the NAIC Health RBC instructions. The following table compares reported capital and surplus to the Company Action Level requirements as of December 31, 2021:

Reported Capital and Surplus	\$634,634,064
Reported Authorized Control Level Risk-Based Capital	\$97,495,148
Computed and Required Company Action Level Risk-Based Capital (200% of Authorized Control Level)	\$194,990,296

b. HMO Net Worth Requirement:

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

the prior calendar year, plus 1.5% of the amount earned in excess of \$150 million for the prior calendar year.

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

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

To determine the minimum net worth requirement as of December 31, 2021, TDCI utilized the greater of (1) the total annual premium revenue earned as reported on the NAIC Annual Statement for the period ending December 31, 2021, plus administrative services only (ASO) payments or (2) the total cash payments made to VSHP by the Division of TennCare plus premium revenue earned from non-TennCare operations for the period ending December 31, 2021.

- (1) For the period ending December 31, 2021, VSHP reported total company premium revenues of \$2,985,824,951 (Schedule T total).
- (2) For the period ending December 31, 2021, VSHP’s total premiums for calendar year 2021 is \$3,917,557,721 (TennCare At-Risk Revenues of \$3,494,055,791 plus Medicare Revenues of \$383,972,608 plus ASO payments of \$39,529,322.)

Utilizing \$3,917,557,721 as the premium revenue base, VSHP’s minimum net worth requirement as of December 31, 2021, is \$62,513,366 ($\$150,000,000 \times 4\% + (\$3,917,557,721 - \$150,000,000) \times 1.5\%$). VSHP’s reported net worth at December 31, 2021, was \$572,120,698 in excess of the required minimum.

2. Restricted Deposit

TCA § 56-32-112(b) sets forth the requirements for VSHP’s restricted deposit. VSHP’s restricted deposit agreement and safekeeping receipts currently meet the requirements of TCA § 56-32-112(b). Utilizing all total premiums for calendar year 2021 of \$3,917,557,721. VSHP’s restricted deposit requirement as of

December 31, 2021, is \$20,800,000. VSHP has on file with TDCI, a depository agreement and properly pledged safekeeping receipts totaling \$20,800,000 to satisfy restricted deposit requirements.

3. Claims Payable

VSHP reported \$266,068,262 claims unpaid as of December 31, 2021. Of the total claims unpaid reported, \$229,098,779 represented the claims unpaid for TennCare operations. The reported amount was certified by a statement of actuarial opinion.

Analysis by TDCI of the triangle lag payment reports through June 30, 2022, for dates of services before January 1, 2022, and review of subsequent NAIC financial filings determined that the reported claims payable for TennCare operations was adequate.

B. TennCare Operating Statements

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

The AATS between VSHP and the State of Tennessee does not currently hold VSHP financially responsible for medical claims. This type of arrangement is considered “administrative services only” (ASO) by the NAIC. Under the NAIC guidelines for ASO lines of business, the financial statements for an ASO exclude all income and expenses related to claims, losses, premiums, and other amounts received or paid on behalf of the uninsured ASO. In addition, administrative fees and revenue are deducted from general administrative expenses. Further, the ASO lines of business have no liability for future claim payments; thus, no provisions for incurred but not reported (IBNR) are reflected on the balance sheet.

Although VSHP is under an ASO arrangement as defined by NAIC guidelines, the AATS requires a deviation from ASO reporting guidelines. The required submission of the TennCare Operating Statement should include quarterly and year-to-date revenues earned and expenses incurred as a result of the contractor’s participation in the State of Tennessee’s TennCare program as if TennCare Select is operating at-risk. As stated in Sections 2.30.16.3.3 and 2.30.16.3.4 of the AATS, VSHP is to provide “an income statement detailing the CONTRACTOR’s fourth quarter and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR’s participation in the State of Tennessee’s TennCare Program.” TennCare HMOs provide this information each quarter on the Report 2A submitted as a supplement to the NAIC financial statements.

For the year ended December 31, 2021, VSHP's TennCare Select Operating Statement reported Total Revenues of \$362,302,760, Medical Expenses of \$308,716,707, Administrative Expenses of \$52,053,837, Income Tax Expense of \$238,832 and Net Income of \$1,293,384.

2. TennCare Operating Statement for At-Risk Operations

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

Based on VSHP's combined regional BlueCare Operating Statements for the year ended December 31, 2021, BlueCare had Total Revenues of \$2,818,922,778, Medical Expenses of \$2,265,444,874, Administrative Expenses of \$418,146,138, Income Tax Expense of \$21,094,654 and Net Income of \$114,237,112.

No reportable deficiencies were noted in the preparation of the TennCare Operating Statements for the period ending December 31, 2021. The TennCare Operating Statements are separate schedules in the VSHP 2021 NAIC Annual Statement which can be found at <https://www.tn.gov/commerce/tenncare-oversight/reports/managed-care-organization-financial-reports>.

C. Medical Fund Target Report

Section 2.30.15.2.1 of the AATS requires:

For the purpose of monitoring actual medical expenses, TennCare shall establish a Medical Fund Target by eligibility grouping for TennCare Select. The CONTRACTOR shall submit a monthly Medical Fund Target Report with cumulative year to date calculation. The CONTRACTOR shall report all medical expenses and complete the supporting claims lag tables. This report shall be accompanied by a letter from an actuary, who may be an employee of the CONTRACTOR, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy. The CONTRACTOR shall also file this report with its NAIC filings due in March and August of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report shall reconcile to NAIC filings including the supplemental TennCare income statement. The CONTRACTOR shall also reconcile the amount paid reported on the supporting claims lag tables to the amount paid for the corresponding period as reported on the CONTRACTOR's encounter file submission as specified in Sections 2.30.17.3 and 2.23.4.

The Medical Fund Target (MFT) reports medical payments and IBNR based upon month of service as compared to a target monthly amount for the enrollees' medical expenses. Although estimates for incurred but not reported claims for ASO plans are not included in the NAIC financial statements, these estimates are required to be included in the MFT. VSHP submitted monthly MFT reports which reported actual and estimated monthly medical claims expenditures to be reimbursed by the Division of TennCare. The estimated monthly expenditures are supported by a letter from an actuary which indicates that the MFT estimates for IBNR expenses have been reviewed for accuracy.

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

D. Medical Loss Ratio Report

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

VSHP submits medical loss ratio (MLR) reports for each at-risk region on the basis of the State's fiscal year which ends on June 30. The medical loss ratio percentage is based upon total medical payments plus incurred but not reported (IBNR) claims estimate divided by capitation revenue net of premium tax. TDCI performs an analysis of each region and for all regions combined. VSHP's MLRs for the period July 1, 2021, through December 31, 2021, were submitted January 31, 2022. Based on TDCI's analysis, the combined medical loss ratio with capitation revenue net of premium tax was 92.0% for this period. VSHP's June 2022 MLRs were submitted on July 20, 2022. Based on an analysis of VSHP's June 2022 MLRs, for the period July 1, 2021, through December 31, 2021, the combined medical loss ratio was 90.9%. The reason for the decrease in the MLR percentage was due to adjustments of IBNR estimates. Over time the IBNR estimates can be reduced with the submission and payment of actual claims.

VSHP submits MLR reports for CoverKids on the basis of the State's fiscal year which ends on June 30. The MLR percentage is based upon total medical payments

plus the incurred but not reported (IBNR) claims estimate divided by capitation revenue net of premium tax. TDCI performs an analysis of CoverKids. CoverKids MLR for the period July 1, 2021, through December 31, 2021, was submitted January 31, 2022. Based on TDCI's analysis, the medical loss ratio with capitation revenue net of premium tax was 96.1% for this period. VSHP's CoverKids June 2022 MLRs were submitted on July 20, 2022. Based on an analysis of VSHP's CoverKids June 2022 MLRs, for the period July 1, 2021, through December 31, 2021, the medical loss ratio was 86.8%. The CoverKids medical loss ratio approximates the combined MLR percentage for all of VSHP. The reason for the decrease in the MLR percentage was due to adjustments of IBNR estimates. Over time the IBNR estimates can be reduced with the submission and payment of actual claims. The procedures and supporting documents to prepare the MLR report were reviewed. No discrepancies were noted during the review of documentation supporting the amounts reported on the MLR report.

E. Administrative Expenses and Management Agreement

For the year ended December 31, 2021, VSHP reported total Administrative Expenses of \$445,871,524 which included direct expenses incurred by VSHP and administrative and support services fees paid pursuant to the administrative services agreement between VSHP and BCBST. Administrative Expenses represented approximately 15% of total premium revenue.

The administrative services agreement requires BCBST to perform certain administrative and support services necessary for the operation of VSHP. These services include, but are not limited to, finance, management information systems, claim administration, telephonic member and provider services support, legal, regulatory, and provider credentialing. The fees paid to BCBST are based upon a cost allocation method consistent with NAIC Statement of Statutory Accounting Principles (SSAP) No. 70.

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

For the year ended December 31, 2021, net allocated expenses of \$236,974,140 were charged by BCBST. Allocated expenses are the result of administrative and support services fees paid pursuant to the administrative services agreement between VSHP and BCBST.

The administrative services agreement was previously approved by TDCI and the Division of TennCare. The allocation methodologies utilized by VSHP were

reviewed by TDCI. No deficiencies were noted during the review of the administrative services agreement.

F. Schedule of Examination Adjustments to Capital and Surplus

No adjustments are recommended to Capital and Surplus for the period ending December 31, 2021, as a result of the examination of VSHP's TennCare operations.

VI. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

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

The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine-point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.

(A) "Pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.

(B) "Process" means the health maintenance organization must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either that the claim had been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice must specifically identify all such information and documentation.

TDCI currently determines compliance with Tenn. Code Ann. § 56-32-126(b)(1) by testing monthly data file submissions from each of the TennCare MCOs. Each month is tested in its entirety for compliance with the prompt pay requirement of the

statute. If a TennCare MCO fails to meet the prompt pay standards for any subsequent month after the month in which non-compliance was communicated by TDCI, the MCO will be penalized as allowed by the statute in an amount not to exceed ten thousand dollars (\$10,000). The TennCare MCO is required to maintain compliance with prompt pay standards for twelve months after the month of failure to avoid the penalty.

Prompt Pay Results for All Claims Processed

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

VSHP All TennCare Operations	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2021	100%	100.0%	Yes
February 2021	99%	100.0%	Yes
March 2021	100%	100.0%	Yes
April 2021	100%	100.0%	Yes
May 2021	100%	100.0%	Yes
June 2021	100%	100.0%	Yes
July 2021	100%	100.0%	Yes
August 2021	100%	99.9%	Yes
September 2021	100%	100.0%	Yes
October 2021	100%	100.0%	Yes
November 2021	100%	100.0%	Yes
December 2021	99%	100.0%	Yes

When combining the results for all claims processed, VSHP was in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for all months in calendar year 2021.

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

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

- The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for NEMT services delivered to a member are processed within thirty (30) calendar days of the receipt of such claims.
- The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all NEMT provider claims for covered NEMT services delivered to a member.

Prompt pay testing by TDCI determined that the NEMT subcontractor, Southeastrans, Inc., processed claims in compliance with Sections A.15.3 and A.15.4 of ATTACHMENT XI to the CRA and the AATS for all months in calendar year 2021.

Prompt Pay Results for CHOICES Claims

Pursuant to Section A.2.22.4.4 of the CRA and Section 2.22.4.4 of the AATS, VSHP is required to comply with the following prompt pay claims processing requirements for nursing facility claims and for certain home and community-based services (HCBS) claims submitted electronically in a HIPAA-compliant format:

- Ninety percent (90%) of clean claims for nursing facility services and HCBS excluding personal emergency response systems (PERS), assistive technology, minor home modifications, and pest control shall be processed and paid within fourteen (14) calendar days of receipt.
- Ninety-nine point five percent (99.5%) of clean claims for nursing facility and HCBS other than PERS, assistive technology, minor home modifications, and pest control shall be processed and paid within twenty-one (21) calendar days of receipt.

Prompt pay testing determined that BlueCare and TennCare Select nursing facility and CHOICES HCBS claims were processed in compliance with Section A.2.22.4.4 of the CRA and Section 2.22.4.4 of the AATS for all months in calendar year 2021.

Prompt Pay Results for ECF CHOICES HCBS Claims

Pursuant to Section A.2.22.4.4 of the CRA, VSHP is required separately to comply with the following prompt pay claims processing requirements for Employment and Community First (ECF) CHOICES HCBS claims for services submitted electronically in a HIPAA-compliant format:

- Ninety percent (90%) of clean claims for ECF CHOICES HCBS shall be processed and paid within fourteen (14) calendar days of receipt.
- Ninety-nine-point five percent (99.5%) of clean claims for ECF CHOICES HCBS shall be processed and paid within twenty-one (21) calendar days of receipt.

Prompt pay testing determined that BlueCare ECF CHOICES HCBS claims were processed in compliance with Section A.2.22.4.4 of the CRA for calendar year 2021.

Prompt Pay Results for CoverKids Claims

VSHP is required to separately comply with the following prompt pay claims processing requirements for CoverKids for Medical and March Vision claims for services submitted electronically in a HIPAA-compliant format:

- Ninety percent (90%) of clean claims for CoverKids shall be processed and paid within fourteen (14) calendar days of receipt.
- Ninety-nine-point five percent (99.5%) of clean claims for CoverKids shall be processed and paid within sixty (60) calendar days of receipt.

Prompt pay testing by TDCI determined that CoverKids claims were processed as compared to the requirements of Tenn. Code Ann. § 56-32-126(b)(1) for all months in 2021.

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

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

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

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

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

- Review of the focused claims testing procedures and responses, and
- Review of internal controls related to claims processing.

C. Claims Payment Accuracy

1. Claims Payment Accuracy Reported by VSHP

Section A.2.22.6 of the CRA and Section 2.22.6 of the AATS require that 97% of claims are processed or paid accurately upon initial submission. On a monthly basis, VSHP submits claims payment accuracy percentage reports by Grand Region and TennCare Select to TennCare based upon audits conducted by VSHP. A minimum sample of one hundred and sixty (160) claims randomly selected from the entire population of electronic and paper claims processed or paid upon initial submission for the month tested is required. Additionally, each monthly sample of one hundred and sixty (160) claims shall contain a minimum of thirty (30) claims associated with nursing facility services provided to CHOICES members and thirty (30) claims associated with home and community-based care services provided to CHOICES members. The testing attributes to be utilized by VSHP are defined in the CRA and the AATS between VSHP and the Division of TennCare. Additionally, subcontractors responsible for processing claims shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor.

VSHP performed and reported compliance with monthly claims payment accuracy requirements for all months in calendar year 2021.

2. Claims Payment Accuracy Reported by the NEMT Subcontractor

ATTACHMENT XI Section A.15.5 of the CRA and the AATS requires VSHP to pay 97% of NEMT claims accurately upon initial submission. Additionally, ATTACHMENT XI Section A.15.6 of the CRA and the AATS requires an audit of NEMT claims that complies with the requirements in the CRA regarding a claims payment accuracy audit. The NEMT subcontractor, Southeastrans, Inc., performed and reported compliance with monthly claims payment accuracy requirements for all months in calendar year 2021.

3. Procedures to Review the Claims Payment Accuracy Reports

The review of the claims payment accuracy reports included interviews with responsible staff of VSHP and Southeastrans, Inc., to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy reports. The review included verification that the number of claims selected by VSHP and the NEMT subcontractor agreed to requirements of Sections A.2.22.6 and ATTACHMENT XI Section A.15.5 and

A.15.6 of the CRA, and Sections 2.22.6 and ATTACHMENT XI Sections A.15.5 and A.15.6 of the AATS. These interviews were followed by a review of the supporting documentation used to prepare the claims payment accuracy reports.

From VSHP's and the NEMT subcontractor's December 2021 claims payment accuracy reports, TDCI judgmentally selected for verification ten VSHP and ten NEMT claims reported as accurately processed by VSHP. TDCI tested these claims to the attributes required in Section A.2.22.6.4 of the CRA and Section 2.22.6.4 of the AATS.

Deviation from Attribute Requirements

Section 2.22.6.4.5 of the CRA and the AATS requires VSHP to determine if the allowed payment agrees with the contracted rate. VSHP's claims payment accuracy testing procedures do not confirm the allowed payment to the amount defined in the providers' contract for each claim tested. VSHP provided the following response as an alternative to verifying that the allowed payment agrees with the contracted rate.

"Codes are developed and updated as needed by Coding and Reimbursement Research (CARR) based upon changes by the governing organizations (e.g., AMA, CMS, etc.). CARR reviews new, deleted, and revised CPT and HCPCS codes for possible impact with existing, active BCBST Medical Policies.

Once codes are received from CARR, Reimbursement Development/Contract Support (RDCS) establishes pricing for the codes based on reimbursement hierarchies (i.e.: TennCare, Medicaid, Medicare (CMS), and applies the pricing to all applicable fee schedules. RDCS then peer reviews these fee schedules and sends them to FCO (Facets Configuration Operation) in the form of an Access table.

CARR also submits drug pricing to RDCS who develops fee schedules using the same process as described above. RDCS maintains a repository in Access of all developed fee schedules.

Upon receiving a fee schedule, the Application Configuration team within FCO performs a mass load of the Access table in the FACETS TEST environment. FCO performs a quality check of the TEST environment and once quality check has passed, the information is placed into production. Application Configuration Services conducts a post-production quality check to ensure that all information is accurate.

After receiving a completion notification email from FCO, RDCS performs a final quality check to ensure the fee schedule rates loaded by FCO align with the fee schedule stored in the Access repository. When the final quality

check has been completed, the fee schedules have passed 5 quality checks. Established fee schedules are published and available for providers to view within the Availity provider portal.

During the claim review process, Internal Audit Quality Assurance auditors verify the accuracy of rates paid by reviewing the pricing tables in the Access repository and recalculate the claim payment by multiplying applicable percentages referenced in the provider contract using rates in the tables to determine the accuracy of the amount paid. In addition, checklist attributes such as duplicate payment, prior authorization, service limitations, etc. are used in determining accuracy of the claim payment.”

TDCI has noted the alternative method for testing the attribute allowed payment to the amount defined in the providers’ contract is acceptable. Fee schedules are updated and the providers are able to view any changes through the Availity provider portal.

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

From VSHP’s and the NEMT subcontractor’s December 2021 claims payment accuracy reports, TDCI judgmentally selected for verification ten VSHP and ten NEMT claims reported as accurately processed. TDCI tested these claims to the attributes required in Section A.2.22.6.4 of the CRA and Section 2.22.6.4 of the AATS.

For the 20 claims selected for verification from VSHP’s and the NEMT subcontractor’s claims payment accuracy reports, no deficiencies were noted by TDCI.

D. Focused Claims Testing

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

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

For monthly focused claims testing by VSHP during calendar year 2021, TDCI judgmentally selected 25 claims from each of the BlueCare East, BlueCare Middle,

BlueCare West, TennCare Select, and CoverKids prompt pay data files submitted by VSHP for prompt pay testing purposes. The focused areas for testing during calendar year 2021 included the following:

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

1. Results of Focused Claims Testing

Each month, TDCI provided VSHP with the claims selected for testing and specified the attributes for VSHP to self-test to determine if the claims were accurately processed. For the 1,475 claims tested for calendar year 2021, VSHP reported at least one attribute error on 47 claims. It should be noted a claim may fail more than one attribute. For the 47 claims, 71 attribute errors were reported by VSHP. The following table summarizes the focused claims testing errors reported by VSHP for the calendar year 2021:

Attribute Tested	Errors Reported by VSHP
Denial Reason Communicated to Provider Appropriate	40
Prior Authorization Obtained if Required	15
Other Insurance Properly Considered	9
Considered Benefit Limit HCBS Provided as Cost Effective Alternative	3
Payment Agrees to Provider Contracted Rate	1
Data Entry Is Verified With Hardcopy Claim	1
Copayment Correctly Considered	1
Patient Liability Correctly Considered	1
Total	71

For the 47 claims that contained attribute errors, VSHP identified 2 that were the result of system errors and 45 that were the result of manual errors. For the system errors, VSHP provided explanations which identified the error that occurred, identified the number of claims affected, and reported when all affected claims had been reprocessed. TDCI requested corrective action plans when additional explanation was deemed necessary. In subsequent monthly focused testing, TDCI selected similar claim types or claim denial reasons to monitor the resolution of system issues.

Management Comments

VSHP Concurrs

2. Deficiencies Noted by TDCI During Focused Claims Testing

TDCI noted claims processing deficiencies in addition to the errors identified by VSHP during monthly focused testing. For each deficiency, TDCI requested VSHP provide additional explanation including the resolution of system configuration issues and the reprocessing of the error claim and all other claims affected by the processing error. The following represent the significant additional items noted by TDCI during monthly focused testing for calendar year 2021:

1. For the April 2021 focused claims testing, a professional claim was denied in error for lack of a Medicare explanation of benefits. The denial reason was not appropriate because the claim was a professional claim, and the Medicare policy only covers hospital inpatient claims. The claim was adjusted to allow payment on the provider's June 4, 2021 remittance advice. There were 298 additional claims for different members/providers identified as denied with this same error. The total dollar amount of all adjustments is \$8,149.79.
2. For the May 2021 focused claims testing, a claim was denied for failure to submit claim timely. Based on the information available to VSHP at the time the claim was processed, the claim should have denied for lack of Medicare explanation of benefits.
3. For the August 2021 focused claims testing, one claim incorrectly denied because the claim system failed to pend the claim for associate intervention to manually bypass the benefit limit. Three additional claims were impacted by this error. The total dollar amount of those three claims was \$249.20 and all claims have been reprocessed.
4. For the August 2021 focused claims testing, VSHP indicated a system error caused a claim to be overpaid based on the patient liability on the primary explanation of benefits. VSHP identified the root cause of the automation error and updated the system configuration on December 28, 2021. The total number of affected claims was 12 with a financial impact of \$926.44. These claims were adjusted on December 3, 2021.

Management Comments

VSHP Concur.

3. Verification by TDCI of Focused Claims Testing Results

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

- TDCI judgmentally selected 41 claims for testing in which no errors were reported by VSHP and,
- TDCI judgmentally selected 46 claims for testing in which VSHP reported errors.

No deficiencies were noted by TDCI during the reverification of the 41 focused in which VSHP reported no errors.

All 46 claims that VSHP reported as inaccurately processed were properly corrected by VSHP.

E. Copayment Testing

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

TDCI requested from VSHP a listing of the 100 enrollees with the highest accumulated copayments for the period January 1, through December 31, 2021. From the listing, five enrollees were judgmentally selected. The claims processed for the five enrollees in calendar year 2021 were analyzed to determine if VSHP had correctly applied copayment requirements of the CRA based upon the enrollee's eligibility status.

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

For 3 enrollees, VSHP did not apply a copayment to a total of 7 clinic specialist claims. A \$20 copayment should have been applied to the enrollee's claim based upon the enrollee's eligibility status.

VSHP stated that for a type of Service "OCMV" is applied to Maternity Practitioner Visit claims and Clinic Specialist claims for members 0-18 to prevent an authorization requirement on these claim types. In April 2021, TennCare requested no copay be taken for facility or physician claims with specific maternity diagnosis. In updating configuration to remove the copay for maternity claims, the configuration team removed the copay requirement

for type of service OCMV, which inadvertently also removed the copay requirement for clinic specialist claims for members 0-18. Configuration will be updated to require a copay for these claim types and affected claims will be identified and adjusted.

Management Comments

VSHP concurs and the configuration was updated on July 24, 2022.

F. Remittance Advice Testing

The purpose of remittance advice testing was to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system. TDCI requested and VSHP provided 41 remittance advices related to claims previously tested by TDCI. No discrepancies were noted.

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

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

TDCI requested VSHP to provide cancelled checks or EFT documentation related to the 41 claims previously tested by TDCI. VSHP provided proof of EFT for all 41 claims. The documents provided agreed with the amounts paid per the remittance advices and no pattern of significant lag times between the issue date and the cleared date was noted.

H. Pended and Unpaid Claims Testing

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

The pended and unpaid data files submitted to TDCI as of June 30, 2022, were reviewed for claims which were unprocessed and exceeded 60 days old from receipt date. The pended and unpaid data file of claims unprocessed by VSHP, as well as subcontractors, indicate a total of 32,496 claims exceeding 60 days in process as of June 30, 2022. VSHP, including subcontractors, processed 790,545 initial submission claims for the month of June 2022. No material liability exists for claims over 60 days old.

The pended and unpaid CoverKids data files submitted to TDCI as of June 30, 2022, were reviewed for claims which were unprocessed and exceeded 60 days old from receipt date. The CoverKids pended and unpaid data file of claims

unprocessed by VSHP, indicate a total of 276 claims exceeding 60 days in process. VSHP's CoverKids, processed 12,428 initial submission claims for the month of June 2022. No material liability exists for claims over 60 days old.

I. Mailroom and Claims Inventory Controls

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

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

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

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

VII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints Received by VSHP

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

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

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

TDCI utilized VSHP's 2021 provider complaint logs to verify the timeliness of provider reconsideration requests. TDCI judgmentally selected 19 provider reconsideration requests for testing. The selection criteria included reconsideration requests with processing lags of less than 30 days, between 30 and 60 days, and greater than 60 days.

The following deficiencies were noted for the 19 reconsiderations requests selected for testing:

- Four reconsideration requests were not resolved within 60 days of receipt. No written agreement was executed between the providers and VSHP to allow additional time to resolve the complaints.
- For one reconsideration request, the received date was incorrectly recorded on the provider complaint log since it did not match the received date stamped on the provider complaint.
- For 11 reconsideration requests, the resolution date was incorrectly recorded on the provider complaint log since it did not match either the remittance date of the reprocessed claim or the date of the resolution letter sent by VSHP to the provider.
- For 12 reconsideration requests which were not resolved within 30 days of receipt, VSHP failed to inform the provider in an acknowledgement letter that a decision would be made within 60 days of receipt. VSHP's policies and procedures and Tennessee Code Annotated requires VSHP to respond to reconsideration requests within 30 days of the receipt of the request. For the deficiencies noted, VSHP explained an acknowledgement letter was not sent within 30 days due to an error found in internal reporting procedures. Currently, VSHP correspondence department uses an inquiry report to determine when 30-day acknowledgement letters are required. The reporting procedures failed to account for reconsiderations that were referred internally for review or investigation to other VSHP departments for response.
- For the 19 reconsideration requests, TDCI reviewed the issues raised by the providers and questions were posed to VSHP for response. Emphasis was placed on discovering deficiencies in the VSHP's claims processing system or provider complaint procedures. For three reconsideration requests, TDCI noted the following manual errors by VSHP associates on initial claims processing:

- For one complaint, VSHP inappropriately allowed a claim to pay at \$0 on initial claims processing. VSHP failed to send the claim to retrospective claim review for pricing. VSHP reprocessed and paid the claim.
- For one complaint, VSHP inappropriately denied a claim for no authorization when the procedure code did not require authorization on initial claims processing. VSHP reprocessed and paid the claim.
- For one complaint, VSHP inappropriately denied a claim requesting a corrected bill on initial claims processing. VSHP reprocessed and paid the claim.

Management Comments

VSHP Concur. To mitigate future occurrences, VSHP has implemented the following controls:

- Created a report that tracks the age of reconsiderations routed to other areas within the enterprise for resolution to ensure that a 30-day acknowledgement letter is mailed to the provider when additional time is needed to resolve the complaint and that the complaint does not age beyond the 60-day time frame.
- Enhanced guidelines so that the complaint log resolution date matches the date of the claim adjustment and the same day resolution letter.

The manual errors were covered with staff and additional training was provided to prevent recurrence.

B. Provider Complaints Received by TDCI

TDCI offers to providers a complaint process for disputes with TennCare MCOs. Complaints may involve claims payment accuracy and timeliness, credentialing procedures, inability to contact or obtain assistance from the MCO, miscommunication or confusion around MCO policy and procedures, etc. When a provider complaint is received, TDCI forwards the complaint to the MCO for investigation. The MCO is required to respond in writing within 30 days to both the provider and TDCI to avoid assessment of liquidated damages pursuant to the "On Request" report requirements of the CRA.

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

For the period January 1 through December 31, 2021, TDCI received and processed 137 provider complaints against VSHP. The responses by VSHP to providers were categorized by TDCI in the following manner:

Previous denial or underpayment reversed in favor of the provider	55
Previous denial or payment upheld	67
Question answered	5
Resolved	4
Previous denial or underpayment partially reversed in favor of the provider	3
Duplicate	2
Withdrawn	1

TDCI judgmentally selected 20 provider complaints that were overturned by VSHP after submission to TDCI by the medical provider. The issues raised by the providers were analyzed and questions were posed to VSHP for response. Emphasis was placed on discovering deficiencies in the VSHP's claims processing system or provider complaint procedures.

Deficiencies were noted during the review of VSHP's review of provider complaint processes. For 13 of the 20 provider complaints, TDCI noted VSHP did not properly consider or adjust associated claims for the tested provider complaints when they were initially submitted to VSHP. Only after the complaints were submitted to TDCI were the 13 complaints properly adjusted. The deficiencies include:

- For one complaint, VSHP inappropriately upheld the denial of a claim for service not performed by the primary care provider. On initial reconsideration by the plan, VSHP failed to research the primary care provider assignment based on the original member identification number.
- For one complaint, VSHP inappropriately upheld the recoupment of a claim for payment by other insurance for a service not provided by the primary care provider on initial processing and subsequent claims adjustment. On initial reconsideration, VSHP failed to recognize the error of the claims adjustment and failed to properly coordinate benefits paid by the other insurer.
- For one complaint, VSHP inappropriately upheld the denial of a claim for a service considered duplicate on the same claim. On initial reconsideration by the plan, VSHP failed to review medical notes which supported that the services were not duplicate.
- For one complaint, VSHP inappropriately upheld the allowed payment of a claim for services at a reduced rate. On initial reconsideration by the plan, VSHP failed to recognize that the original claim had been altered resulting in an incorrect

payment.

- For one complaint, VSHP inappropriately upheld a recoupment of a claim because the member was not treated at the skilled nursing level. The provider noted the claim was not subject to skilled nursing facility consolidated billing. On initial reconsideration by the plan, VSHP failed to send the reconsideration to the provider audit department for further review.
- For one complaint, VSHP inappropriately upheld the denial of a claim for no authorization for a member that was made retro-eligible. On initial reconsideration by the plan, VSHP failed to properly consider retro-eligibility.
- For one complaint, VSHP inappropriately upheld the denial of a claim for explanation of benefits does not match claim when member's primary insurance had termed. On initial reconsideration by the plan, VSHP failed to do a thorough investigation of third-party insurance.
- For one complaint, VSHP inappropriately upheld the recoupment for a procedure code considered invalid. On initial reconsideration by the plan, VSHP failed to ensure that a vendor was properly considering the administration procedure codes for vaccines for children.
- For one complaint, VSHP inappropriately upheld the denial of a claim for no authorization of drug when a substitution was provided during the pandemic related shortage. On initial reconsideration by the plan, VSHP failed to establish procedures for updating authorizations when a substitution is required due to drug shortage.
- For four complaints on initial reconsideration, VSHP upheld the recoupment of these claims based upon medical necessity review. After the complaints were submitted to TDCI, VSHP overturned the recoupment decision. The medical standards applied by VSHP during initial reconsideration were different than medical standards applied after the complaints had been sent to TDCI. The medical standards applied by VSHP should be consistent during review by VSHP upon receipt as a provider complaint and after the complaints are received by TDCI.

Management Comments

VSHP Concur. To address the scenario where VSHP's review standards for reconsiderations differed from those used after the provider submitted a TDCI complaint, VSHP met with our vendor who reviews those reconsideration types and instructed them to incorporate Milliman Care Guidelines along with Clinical Review Judgment as part of their review process. This change ensures that our vendor's review process is consistent with VSHP's process. In addition, ongoing education and process improvements are provided to internal and external

clinicians that provide utilization management and review to determine medical necessity, appropriateness of care and efficiency of health care.

C. Independent Reviews

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

For the period January 1 through December 31, 2021, 65 independent reviews were initiated by providers against VSHP. The following is a summary of final outcomes:

Reviewer decision in favor of VSHP	34
Reviewer decision in favor of the provider	5
Reviewer decision partially for the provider and VSHP	17
Pending	3
Settled for provider	6

TDCI judgmentally selected 5 independent reviews for testing that were overturned by VSHP after submission to TDCI by the medical provider. The issues raised by the providers were analyzed and questions were posed to VSHP for response. Emphasis was placed on discovering deficiencies in the VSHP claims processing system or provider complaint and appeal procedures.

For 3 of the 5 independent reviews select for testing, the medical review standards applied by VSHP during reconsideration was different than the medical review standards applied after the claim was submitted as an independent review to TDCI. The medial standards applied by VSHP should be consistent during review by VSHP upon receipt as a provider complaint and after the complaints is submitted for independent review.

Management Comments

VSHP Concur. To address the scenario where VSHP's review standards for reconsiderations differed from those used after the provider submitted a request for independent review, VSHP met with our vendor who reviews those reconsideration types and instructed them to incorporate Milliman Care Guidelines along with

Clinical Review Judgment as part of their review process. This change ensures that our vendor's review process is consistent with VSHP's process. In addition, ongoing education and process improvements are provided to internal and external clinicians that provide utilization management and review to determine medical necessity, appropriateness of care and efficiency of health care.

D. Provider Manual

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

During the examination period, VSHP submitted multiple updates to the provider manual for prior approval by TDCI and the Division of TennCare. The last update to the provider manual during the examination period was approved by TDCI on November 12, 2021.

E. Provider Agreements

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

Per Section A.2.12.2 of the CRA and Section 2.12.2 of the AATS, all template provider agreements and revisions thereto must be approved in advance by TDCI, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Additionally, Section A.2.12.9 of the CRA and Section 2.12.9 of the AATS report the minimum language requirements for provider agreements. Section A.2.12.9.48 of the CRA and Section 2.12.9.48 of the AATS further state that for modifications that do not require amendments to be valid only when reduced to writing, duly signed and attached to the original of the provider agreement, the terms shall include provisions allowing at least thirty (30) calendar days for providers to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., certified mail, facsimile, hand-delivered receipt, etc.)

From the 41 claims tested above in Section VI.D., TDCI requested the executed

provider agreements for testing. No deficiencies were noted during the review of the provider agreements selected for testing.

F. Provider Payments

Capitation payments to providers were tested during 2021 to determine if VSHP complied with the payment provisions set forth in its capitated provider agreements. TDCI selected a sample of capitated payments from the December 2021 East Tennessee MLR report. Review of payments to capitated providers indicated that all payments were made per the provider contract requirements.

G. Subcontracts

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

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

However, during the review of VSHP's Board of Director Minutes, it was noted that VSHP subcontracted with Axial Healthcare to provide provider utilization management services. The Axial Healthcare subcontract was executed but was not submitted to TDCI and the Division of TennCare for prior approval as required by CRA A.2.26.3. VSHP should ensure procedures are followed to submit subcontracts for prior approval to TDCI and the Division of TennCare.

Management Comments

Management concurs and has implemented a process to ensure all new vendors are reviewed for materiality and related subcontracts are submitted to TDCI for review and approval.

H. Subcontractor Monitoring

The CRA between VSHP and the Division of TennCare allows VSHP to delegate activities to a subcontractor. VSHP is required to reduce subcontractor agreements to writing and specify the activities and report responsibilities delegated to the subcontractor. VSHP should monitor the subcontractor's performance on an ongoing basis. Also, VSHP should identify any deficiencies or areas for improvement and determine the appropriate corrective action as necessary. Section

A.2.26.1 of the CRA and Section 2.26.1 of the AATS states, "If the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6." Additionally, Section A.2.26.8 of the CRA and of the AATS require VSHP to ensure that subcontractors comply with all applicable requirements of the CRA and the AATS, respectively. Federal and state requirements include, but are not limited to, specific regulations regarding non-discrimination, conflicts of interest, lobbying, and offer of gratuities.

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

I. Non-discrimination

Section A.2.28 of the CRA and Section 2.28 of the AATS require VSHP to demonstrate compliance with Federal and State regulations of Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Church Amendments (42 U.S.C. 300a-7), Section 245 of the Public Health Service Act (42 U.S.C. 238n.), and the Weldon Amendment (Consolidated Appropriations Act 2008, Public Law 110-161, Div. G, Sec. 508 (d), 121 Stat. 1844, 2209). Based on discussions with various VSHP staff and a review of policies and related supporting documentation, VSHP was in compliance with the reporting requirements of Section A.2.28 of the CRA and Section 2.28 of the AATS.

J. Internal Audit Function

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

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

K. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., Title 56, Chapter 11, Part 1 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-105 states, “Every insurer and every health maintenance organization that is authorized to do business in this state and that is a member of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner....” VSHP is domiciled in the State of Tennessee and, therefore, the filing is regulated in Tennessee. No discrepancies were noted in the annual holding company registration filing for VSHP received in 2022 for the calendar year 2021.

L. Health Insurance Portability and Accountability Act (HIPAA)

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

VSHP’s and its subcontractor’s information systems policies and procedures were reviewed in relation to the HIPAA and HITECH requirements of the CRA and the AATS. No deficiencies were noted during the review of policies and procedures related to HIPAA and HITECH requirements.

M. Conflict of Interest

Section E.28 of the CRA and Section 5.19 of the AATS warrant that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to VSHP in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

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

Failure to comply with the provisions required by the CRA and the AATS shall result in liquidated damages in the amount of one hundred ten percent (110%) of the total

amount of compensation that was paid inappropriately and may be considered a breach of the CRA and the AATS.

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

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

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

No instances of non-compliance with conflict of interest requirements for VSHP were noted during the examination.

N. Episodes of Care Testing

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

One strategy, Episode-Based Payments, focuses on the health care delivered in association with acute healthcare events such as a surgical procedure or an inpatient hospitalization. Retrospective episode-based payment rewards providers who successfully achieve high quality and efficient outcomes during an "episode of care," a clinical situation with start and end points that may involve multiple independent providers. This approach rewards high-quality care, promotes the use of clinical pathways and evidence-based guidelines, encourages coordination, and reduces ineffective and/or inappropriate care. For each episode type, a principal

accountable provider (also referred to as a PAP or Quarterback) is determined based upon the provider deemed to be in the best position to influence the quality and cost of care for the patient. The design of each episode is aligned for all MCOs. For every enrollee affected, a non-risk adjusted episode spend amount is determined based upon the total cost of claims from all providers that meet design requirements. Risk adjustment is the mechanism that the episode-based models use to achieve a comparison between PAPs. The final risk adjustment methodology decisions are made at the discretion of the MCO after analyzing the data. Each MCO runs its own risk adjustment model because there are variations in the population covered and significant risk factors may vary across MCOs. Episode of care rewards and penalties are in addition to the normal claims payment arrangements between an MCO and a provider and do not have an impact on those arrangements. The MCO sends interim quarterly and final annual reports to each PAP to inform them about their performance in the episode-based payment model. The final provider report will notify the PAP of the total average episode cost (risk adjusted) compared to the acceptable or commendable cost thresholds. PAPs that achieve the commendable cost threshold are rewarded for their high performance in the previous year. PAPs that exceed the acceptable cost threshold are assessed a financial penalty for a share of the amount of costs that were over and above all their peers. A more detailed explanation of episode of care initiative can be found at <https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html>.

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

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

The risk marker supporting files were reviewed to determine if the MCO's risk adjustment model was applied consistently for each episode. Other tests included, but were not limited to, verification of claims data files with claims reported to the Division

of TennCare as encounter data. Also, for each quarter, TDCI selects for testing enrollee episodes excluded from the PAPs average cost calculations.

TDCI selected for testing a total of 100 enrollee included episodes from final and interim reports issued by VSHP from November 2020 through August 2021. Also, TDCI selected for testing 25 enrollee episodes excluded from the PAP average cost calculations. The following table reports the results of episode of care testing by episode of care from final and interim reports issued by VSHP from November 2020 through August 2021.

Results of Episodes of Care Testing

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

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

Appendix

Previous Examination Findings

The previous examination findings are provided for informational purposes. The following were financial, claims processing and compliance deficiencies cited in the examination by TDCI for the period January 1 through December 31, 2019:

A. Financial Deficiencies

No reportable deficiencies were noted in the prior report and the current report during performance of financial analysis procedures.

B. Claims Processing Deficiencies

1. The CRA requires VSHP to self-test the accuracy of claims processing based on claims selected by TDCI on a monthly basis. For the 1,200 claims tested for the calendar year 2019, VSHP reported at least one attribute error on 105 claims during focused claim testing
2. For the October 2019 focused claims testing, VSHP indicated two claims were incorrectly denied for provider must file this claim with Tennessee Bureau of Medicaid. The providers had appropriately obtained prior authorization for the services from VSHP. VSHP noted that internal procedures failed to recognize the authorizations and then inappropriately denied the claims as the responsibility of the Tennessee Bureau of Medicaid. VSHP submitted a corrective action plan to TDCI stating the issue had been resolved. Fifty (50) claims were impacted by this error and reprocessed with an additional paid amount of \$197,717.
3. For one of the five enrollees selected for copayment testing, VSHP incorrectly applied \$5.00 copayments on two separate procedures on a single claim. A copayment should only be applied once per claim.

Finding 1 and 3 have been repeated in the current examination.

C. Compliance Deficiencies

1. Eleven (11) of the 28 reconsideration requests selected were not resolved by VSHP within 30 days of receipt and VSHP failed to inform the providers that a decision would be made within 60 days of receipt.
2. Ten (10) of the 28 reconsideration requests tested were not resolved within 60 days. No written agreement with the provider and VSHP was executed to allow additional time to resolve the complaint.

3. Two (2) of 100 non-excluded episodes selected from the 2019 episodes of care quarterly reports were not valid episodes and should have been classified as excluded episodes. The episode trigger claim occurred in a Federally Qualified Health Center (FQHC) or a Rural Health Center (RHC), therefore, per the episodes of care detailed business requirements, the episodes should have been excluded.

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