

Vanderbilt Health Plans, Inc.

For the Period

January 1, 1997, Through December 31, 1998

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John G. Morgan
Comptroller

March 17, 2000

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and

The Honorable John Ferguson, Commissioner
Department of Finance and Administration
First Floor, State Capitol
Nashville, Tennessee 37243-00285

Ladies and Gentlemen:

Pursuant to the agreement between the Comptroller of the Treasury and the Department of Finance and Administration, the Division of State Audit performs examinations of managed care organizations participating in the Tennessee TennCare Program under Title XIX of the Social Security Act.

Submitted herewith is the report of the examination of Vanderbilt Health Plans, Inc., for the period January 1, 1997, through December 31, 1998.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/pn
00/011

cc: Joe Keane
Theresa Clarke-Lindsey
John S. Tighe

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

TennCare Report

Vanderbilt Health Plans, Inc.

For the Period January 1, 1997, Through December 31, 1998

1. Management Did Not Provide Requested Information

Vanderbilt Health Plans, Inc., did not provide requested information and/or was restrictive with the flow of information necessary to conduct the examination in a timely manner (page 7).

2. Deficiencies in Claims Processing System

Vanderbilt Health Plans, Inc., has not fulfilled contract reporting requirements and processing efficiency requirements specified by the TennCare contract (page 8).

3. Deficiencies in Provider Contract Language

Vanderbilt Health Plans, Inc., did not include in the provider agreements all requirements specified by the TennCare contract (page 10).

4. Failure to File Audited Financial Statements

Vanderbilt Health Plans, Inc., did not file audited financial statements for the year ended December 31, 1998, as required by the TennCare contract (page 13).

"Audit Highlights" is a summary of the report. To obtain the complete report which contains all findings, recommendations, and management comments, please contact

Comptroller of the Treasury, Division of State Audit
1500 James K. Polk Building, Nashville, TN 37243-0264
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**TennCare Report
Vanderbilt Health Plans, Inc.
For the Period January 1, 1997, Through December 31, 1998**

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Vanderbilt Health Plans, Inc.
For the Period January 1, 1997, Through December 31, 1998

INTRODUCTION

PURPOSE AND AUTHORITY OF THE EXAMINATION

The terms and conditions for authorizing the TennCare Program, as well as the contracts between the state of Tennessee and the managed care organizations (MCOs) require that examinations of the managed care organizations be conducted by the Tennessee Comptroller's Office. The contract between the Tennessee Department of Finance and Administration and the State Comptroller's Office also contains a provision requiring the examinations.

Under their contract with the state, the MCOs have asserted to comply with stated requirements regarding their provision of services to TennCare enrollees. The purpose of our examination is to render an opinion on the MCOs' assertions that they have complied with certain financial related requirements of their contract with the state.

BACKGROUND

The Tennessee Department of Finance and Administration is the single state agency responsible for administering the TennCare Program and the TennCare Partners Program. On January 1, 1994, the TennCare Program began as an approved federal waiver replacing the then existing Medicaid Program. TennCare encompasses all services other than mental health and long-term care. On July 1, 1996, the TennCare Partners Program was initiated. TennCare Partners, which functions in the same manner as the regular TennCare Program, covers mental health services. Long-term care continues to be excluded from all TennCare waivers. The state contracts with private health maintenance organizations to provide TennCare services to beneficiaries. The health maintenance organizations (HMOs) are referred to as "managed care organizations" (MCOs).

Recipients who meet Medicaid eligibility standards are enrolled in the TennCare Program and TennCare Partners Program. In addition, certain uninsured and uninsurable individuals are eligible for enrollment. Uninsured persons may be required to pay a monthly premium. The contracting MCO provides care for TennCare enrollees for a stated monthly capitation fee. The MCOs in turn arrange for a network of hospitals, doctors, and other health care providers to furnish health care services for persons enrolled in the plan. Essentially, the program functions much the same as a conventional health care delivery system under managed care.

Vanderbilt Health Plans, Inc. (VHP), a Tennessee corporation which is wholly owned by Vanderbilt Health Services, Inc., was incorporated on May 14, 1993, as a health maintenance

organization for the purpose of providing managed health care services to residents of Tennessee, including those participating in the State of Tennessee's TennCare Program. Effective January 1, 1994, VHP contracted with the State of Tennessee as a health maintenance organization (HMO) to provide medical services under the newly established TennCare Program. VHP owns 100% of Vanderbilt Management Service, Inc., the management company. VHP also owns 92% of Health 123, a Tennessee based Commercial and Medicare HMO. Vanderbilt Management Services owns 8% of Health 123. In the second quarter of 1998, Health 123, Inc., merged with TriPoint Health Plan, Inc., a Tennessee commercial licensed HMO. TriPoint was also an indirect subsidiary of VHP (wholly owned before the merger by Vanderbilt Management Services, Inc.). The management agreement between VHP and Vanderbilt Management Service, Inc., grants Vanderbilt Management Service, Inc., the authority to supervise and manage the day-to-day operations of the plan. Vanderbilt Management Service, Inc., is paid a management fee, based on a declining scale, from 15% to 12% of annual premium revenue plus a performance incentive of 1% of the plan's gross revenue.

At December 31, 1997, the enrollment in the TennCare program for VHP was approximately 11,887 members. At December 31, 1998, the enrollment in the TennCare program for VHP was approximately 11,587 members.

VHP files quarterly and annual statements with the Tennessee Department of Commerce and Insurance. This department uses the information filed in these reports to determine if the plan meets the minimum requirements for statutory reserves. The statements are filed on a *statutory* basis of accounting, which differs from generally accepted accounting principles in that "admitted" assets must be easily converted to cash to pay for outstanding claims. "Nonadmitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and are reduced from equity.

The annual statement for the year ended December 31, 1997, reported \$6,475,306 in plan assets; \$3,790,481 in liabilities; and \$2,684,825 net worth. The plan maintained a restricted deposit of \$914,329 as of December 31, 1997. A separate balance sheet for TennCare operations is not required for annual statement purposes. A separate statement of revenues, expenses, and net worth for TennCare operations for the year ended December 31, 1997, reported total revenues of \$8,383,857; medical expenses of \$13,951,720; and administrative expenses of \$2,734,552, resulting in a net loss of \$8,302,416. Revenue comprises \$17,549,007 in capitation fee payments from TennCare; \$299,879 in investment income; and (\$9,465,028) in results of subsidiary. Medical expenses represent 79.50% of capitation fee payments from TennCare, and administrative expenses less premium taxes represent 13.58% of capitation fee payments from TennCare.

The annual statement for the year ended December 31, 1998, reported \$10,297,798 in plan assets; \$4,648,438 in liabilities; and \$5,649,360 net worth. The plan maintained a restricted deposit of \$913,738 as of December 31, 1998. A separate balance sheet for TennCare operations is not required for annual statement purposes. A separate statement of revenues, expenses, and net worth for TennCare operations for the year ended December 31, 1998, reported total revenues of \$18,199,608; medical expenses of \$15,703,444; and administrative expenses of

\$2,687,684, resulting in a net loss of \$191,520. Revenue comprises \$17,880,847 in capitation fee payments from TennCare, and \$318,761 in investment income. Medical expenses represent 87.82% of capitation fee payments from TennCare, and administrative expenses less premium taxes represent 13.23% of capitation fee payments from TennCare.

SCOPE OF THE EXAMINATION

Our examination covers certain financial related requirements of the contract between the state and VHP for the period January 1, 1997, to December 31, 1998. The requirements covered are referred to under management's assertions specified later in the Independent Accountant's Report. Our examination does not cover those portions of the contract concerning quality of care and clinical and medical requirements.

PRIOR EXAMINATION FINDINGS

The previous examination of VHP for the year ended December 31, 1996, included the following findings:

Deficiencies in Claims Processing System

VHP did not fulfill contract reporting requirements and processing efficiency requirements. Errors were discovered in the payment and denial of medical claims.

Deficiencies in Provider Agreements

VHP did not include in the provider agreements all requirements specified by the TennCare contract.

The findings concerning deficiencies in the claims processing system and deficiencies in provider agreements will be repeated in the current report (see the Findings and Recommendations section of this report).

RESULTS OF THE EXAMINATION

Our examination of the plan revealed discrepancies in the claims processing system, provider agreements, accounting, and financial data. These discrepancies are further discussed in the Findings and Recommendations section of the report.

No adjustments were considered necessary for reporting purposes for the period January 1, 1997, through December 31, 1997. Subsequent material events and corrections affected the reporting of the operations of VHP for the period January 1 through December 31, 1998. VHP's equity was adjusted by the Division of State Audit as follows:

- TennCare adverse selection revenue should be increased by \$691,000 and TennCare payable should be decreased by \$691,000 to remove the payable due to TennCare for adverse selection.
- 1998 TennCare adverse selection revenue and TennCare receivables should be increased by \$852,971.58 to adjust the adverse selection receivable amount to the actual amount received in 1999.
- Premium taxes should be increased by \$30,879.43 and management fee expenses should be increased by \$200,716.31 to reflect the additional accrual of the adverse selection payments received in 1999.
- Premium taxes should be increased by \$35,081.94 to correct an error in the calculation of reported premium taxes for the period ending December 31, 1998.

The effect of examination adjustments on the net loss for the TennCare operations of VHP is to change net loss from \$25,694,570.00 to \$24,417,276.10 as of December 31, 1998. The adjustments will increase equity by \$1,277,293.90. VHP was in compliance with the minimum net worth requirement of \$1,500,000 at December 31, 1998.

Management's Comment

VHP would consider recording the \$691,000 adjustment for adverse selection and the \$852,971 adjustment for TennCare adverse selection receivables.

Correspondingly, VHP believes that an increase in the December 31, 1998 IBNR reserves by \$1,000,000 could be appropriate in order to provide additional assurances that the Health Plan is adequately and conservatively reserved.

The effect of the adjustment proposed, along with VHP's suggested changes, would be to reduce the net loss and increase equity by \$277,293.90. The effect of these adjustments would not be material to the net operation of VHP and, therefore, management believes that no formal adjustments are required to be made.



STATE OF TENNESSEE
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DEPARTMENT OF AUDIT
DIVISION OF STATE AUDIT

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Independent Accountant's Report

October 29, 1999

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and

The Honorable John Ferguson, Commissioner
Department of Finance and Administration
First Floor, State Capitol
Nashville, Tennessee 37243-0285

Ladies and Gentlemen:

We have examined management's assertions included in its representation letter dated October 4, 1999, that Vanderbilt Health Plans, Inc., complied with the following requirements during the period January 1, 1997, through December 31, 1998:

- Annual and quarterly statements have been properly filed with the state in accordance with the National Association of Insurance Commissioners (NAIC).
- The organization is in compliance with the minimum equity requirements of the contract with the state.
- The organization is in compliance with member service provisions of the contract with the state.

As discussed in management's representation letter, management is responsible for ensuring compliance with those requirements. Our responsibility is to express an opinion on management's assertions about the organization's compliance based on our examination.

Our examination was made in accordance with standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence about the compliance of Vanderbilt Health Plans, Inc., with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination on the compliance of Vanderbilt Health Plans, Inc., with specified requirements.

Our examination disclosed the following material noncompliance applicable to Vanderbilt Health Plans, Inc.:

- Contracts with subcontractors and providers do not contain the required elements.
- Claims processing does not meet the standards required in the contract with the state.
- The organization is not in compliance with reporting standards specified in the contract with the state.

In our opinion, except for the material noncompliance described in the above paragraph, management's assertions that Vanderbilt Health Plans, Inc., complied with the aforementioned requirements for the period January 1, 1997, through December 31, 1998, is fairly stated, in all material respects.

This report is intended solely for the use of the Tennessee General Assembly and the Tennessee Department of Finance and Administration. However, this report is a matter of public record and its distribution is not limited.

Sincerely,



Arthur A. Hayes, Jr., CPA, Director
Division of State Audit

AAH/pn

FINDINGS AND RECOMMENDATIONS

1. Management did not provide requested information

Finding

VHP did not provide requested information timely during the examination. Several times, the same information had to be requested more than once. As a result, the engagement was excessively delayed, resulting in additional costs to conduct the review. Although it did not result in a scope limitation for the examination, some requested information was never received.

Section 2-13 of the contract between the plan and the state specifies that “the CONTRACTOR shall make all records available at the CONTRACTOR’s expense for review, audit, or evaluation by authorized federal, state, and Comptroller of Treasury personnel.” Also, Section 2-16 of the contract specifies that “the CONTRACTOR shall make available to TennCare or its representatives and other authorized state and federal personnel ... all records, books, documents, and other evidence pertaining to this Agreement, as well as appropriate administrative and/or management personnel who administer the plan.”

Recommendation

Management should cooperate fully with Comptroller of Treasury personnel and provide information necessary to conduct the examination in a timely manner.

Management’s Comment

The management and staff of VHP were helpful and cooperative with the Comptroller’s staff and did not intentionally delay the audit process. VHP provided all documents requested by the Comptroller’s staff during the audit, except for the five items noted in the Missing Documents Report. The five items not provided to the Comptroller’s staff by VHP during the audit were: FYE 12/31/98 Audited GAAP financial statements, FYE 12/31/98 Premium Tax Returns, a memo documenting the actual day claims processing checks are mailed, six specific claims, and an explanation of a benefit accumulator problem on three enrollees. VHP’s specific responses to these items are as follows:

- I. The December 31, 1998 Audited GAAP financial statements were not provided. These statements were delayed by KPMG, pending the resolution of financial issues related to Health 1-2-3.

- II. The December 31, 1998 Premium Tax Returns are a matter of public record and can be obtained upon request from the Tennessee Department of Commerce and Insurance or VHP.
- III. A memo documenting the actual day claims processing checks are mailed is available upon request.
- IV. We did not provide original copies of six of the sixty claims reviewed. We did obtain four of these claims from the providers; however, we are still researching these six claims.
- V. A memo documenting an explanation of a benefit accumulator problem on three enrollees is available upon request.

We transferred the adjudication of the claims process to SMS as of September 1, 1999. The intent of this transfer was to specifically address and correct the deficiencies noted by the State. We would like to note that in the most recent claim audit, conducted by the TennCare Division of the Tennessee Department of Commerce and Insurance (January 18 through February 11, 2000), VHP was commended for its responsiveness and cooperation in providing information and access to all documents and personnel.

2. Deficiencies in claims processing system

Finding

VHP has not fulfilled contract reporting requirements and processing efficiency requirements. A review of 60 claims for services provided from January 1, 1997, through December 31, 1998, revealed the following:

- a) VHP did not meet the claims processing requirements specified by the TennCare contract. Clean claims submitted by providers for medical services were not always processed within the 40-day requirement. The processing lags include an adjustment to the adjudication date. VHP's final adjudication date used to calculate the lag is the date checks and remittance advices are printed. The processing lag has been adjusted to calculate the lag using the date the checks and remittance advices are mailed. Of the 60 claims examined, 47 were clean claims with the following time lags:
 - b)
 - 23 claims within 30 days (49%)
 - 5 claims within the next 10 days (11%)
 - 9 claims within 41 to 60 days (19%)

- 10 claims over 60 days (21%)
- c) Six claims could not be located.
- d) Seven claims did not have all encounter data elements in the system.
- Five of these claims were missing diagnosis codes.
 - Two claims had information entered incorrectly.
- e) Three emergency service claims were denied in error.
- f) One claim correctly denied but with an incorrect denial code.
- g) One claim correctly denied but with the incorrect denial code. The denial was reversed and the claim paid but should have denied.
- h) Three claims have received dates in the system that are different from the date stamp on the claim.
- i) Three enrollees appear to have incorrect benefit accumulator amounts. Written explanations were requested from VHP concerning these discrepancies but the explanations have not been received by State Audit.
- j) VHP does not have the ability to accept electronic claims. Section 2-2(g) of the TennCare contract requires the MCO “to move to electronic billing for all of their TennCare plans offered in Tennessee no later than January 1, 1997.”

The inaccuracies and inefficiencies in the claims processing system indicate VHP’s failure to fulfill the claims processing requirements of the TennCare contract.

Recommendation

VHP should adhere to contract reporting requirements and processing efficiency requirements for claims processing. All date elements required for individual encounter/claims data reporting should be recorded from claims submitted by providers. Claims should be correctly paid or denied in the time required by the TennCare contract. The correct date received should be entered in the claims processing system. Benefit accumulators should accurately accumulate the deductible and out of pocket amount. VHP should offer electronic billing to its providers.

Management’s Comment

It is the policy of VHP to process claims within 30 days of receipt. The majority of the care for VCC members is provided by the Vanderbilt network. Thus, the majority of the claims are submitted by and paid to Vanderbilt. Out-of-network claims require additional processing time which may increase payment times. We are working to control out-of-network utilization and to streamline the process of documenting and paying out of network.

VHP has outsourced claim processing to Shared Medical Systems (SMS). The system conversions necessary to complete outsourcing resulted in a claim backlog. However, the process of receiving and paying claims has been streamlined to the providers' benefit.

Claims are now assigned a number when microfilmed which includes the receipt date. This type of numerical coding ensures that the actual receipt date is captured in the system. The current process of microfilming and numerical coding results in easier and more timely retrieval of claims.

During the system conversion, management revised and clarified claims policies and procedures. It is required that all data elements from the claim be entered into the system. The current system is only limited to the number of diagnosis codes that can be entered.

The system conversions also enabled us to automate many claims procedures that previously required manual intervention by Processors. Through the automation of denials, authorization linkage to claims and benefit accumulators, many of the errors identified in the audit will be alleviated once the system conversion is complete.

We are currently working towards achieving EDI capabilities.

3. Deficiencies in provider contract language

Finding

VHP, Inc., did not comply with the Bureau of TennCare's requirements for provider agreements. The provider agreements did not contain all requirements specified in Section 2-18 of the contract between TennCare and VHP, Inc.

Language describing the following requirements is excluded or deficient in the contract between VHP, Inc., and its providers:

- j. If the provider performs laboratory services, the provider must meet all applicable requirements of the Clinical Laboratory Improvement Act (CLIA) of 1988 at such time that HCFA mandates the enforcement of the provisions of CLIA;

- p. Specify that the CONTRACTOR shall monitor the quality of services delivered under the agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TENNCARE;
- q. Require that the provider comply with corrective action plans initiated by the CONTRACTOR;
- w. Provide for payment within thirty (30) calendar days to the provider upon receipt of a clean claim properly submitted by the provider;
- x. Specify that the provider shall accept payment or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor), plus the amount of any applicable deductibles, copayments and/or special fees as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the enrollee in excess of the amount of applicable deductibles, copayments and/or special fees. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the patient being served;
- y. Specify that at all times during the term of the agreement, the provider shall indemnify and hold TENNCARE harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Agreement between TENNCARE and the MCO. This indemnification may be accomplished by incorporating Section 4-19 of the TENNCARE/MCO Agreement in its entirety in the provider agreement or by use of other language developed by the MCO and approved by TENNCARE;
- dd. Specify that both parties recognize that in the event of termination of this Agreement between the CONTRACTOR and TENNCARE for any of the reasons described in Section 4-2 of this Agreement, the provider agreement shall terminate immediately and the provider shall immediately make available, to TENNCARE, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the MCO provider agreement. The provision of such records shall be at no expense to TENNCARE;
- ee. As of October 31, 1995 contain a provision requiring resolution of disputes by arbitration, approved by TENNCARE, which shall include the following or similar language: Specify that if any dispute arises between the parties involving a contention by one party that the other has failed to perform its obligations and responsibilities under the agreement, then the party making such contention shall promptly give written notice to the other. Such notice shall set forth in detail the basis for the party's contention, and shall be sent by Certified Mail - Return Receipt Requested. The other party shall within thirty (30) calendar days after receipt of the notice provide a written response seeking to satisfy the party that gave notice regarding the

matter as to which notice was given. Following such response, or the failure of the second party to respond to the complaint of the first party within thirty (30) calendar days, if the party that gave notice of dissatisfaction remains dissatisfied, then that party shall so notify the other party and the matter shall be promptly submitted to inexpensive and binding arbitration in accordance with the Tennessee Uniform Arbitration Act at *Tennessee Code Annotated* Section 29-5-301 et seq., with the costs of establishing any arbitration procedure being borne by the CONTRACTOR. TENNCARE shall have no involvement in said arbitration except to (1) enforce this subsection (2) approve the arbitration procedure proposed by the CONTRACTOR and (3) to voluntarily intervene if TENNCARE deems intervention to be in the best interest of the system provided however that TENNCARE shall not be bound by said arbitration. If at any time TENNCARE decides that a particular dispute should be in a court of competent jurisdiction, TENNCARE shall notify the parties to the dispute of its decision to refer the dispute to a court of competent jurisdiction and said arbitration process shall cease and the dispute shall be heard in said court. The only exception to the arbitration process shall be resolution of the cost for emergency medical services in Section 2-3.j.2. If a dispute between the parties involving a claim submitted by a provider to the CONTRACTOR is not resolved prior to entry of a final decision by the arbitrator(s), then the prevailing party at the arbitration shall be entitled to award of reasonable attorney's fees and expenses from the non-prevailing party. Reasonable attorney's fees means the number of hours reasonably expended on the dispute multiplied by a reasonable hourly rate, and shall not exceed ten percent (10%) of the total monetary amount in dispute or \$500.00 whichever amount is greater.

- ff. Include a conflict of interest clause as stated in Section 4-7 of this Agreement between the CONTRACTOR and TENNCARE;
- hh. Specify that the provider shall be required to accept TennCare reimbursement amounts for services provided under the agreement between the provider and CONTRACTOR to TennCare enrollees and shall not be required to accept TennCare reimbursement amounts for services provided to persons who are covered under another health plan operated or administered by the CONTRACTOR;
- ii. Specify that the provider must adhere to the Quality of Care Monitors included in this Agreement as Attachment IV;
- jj. Specify that a provider shall have at least one hundred and twenty (120) calendar days from the date of rendering a health care service to file a claim with the CONTRACTOR and no more than one hundred eighty (180) calendar days from the date of rendering a health care service to file an initial claim with the CONTRACTOR except institutions regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the plan with a retroactive eligibility date. In situations of enrollment in the plan with a retroactive eligibility date, the minimum and maximum time frames for filing a claim

shall begin on the date that the CONTRACTOR received notification from TENNCARE of the enrollee's eligibility; and

- ll. Require that the provider display notices of the enrollee's right to appeal adverse decisions affecting services in public areas of their facility(s) in accordance with TennCare rule 1200-13-12-11.

Recommendation

VHP should comply with the TennCare Bureau's requirements regarding provider agreements. The provider agreements should contain all items as specified in Section 2-18 of the TennCare contract.

Management's Comment

Management is in the process of recontracting with our TennCare providers using approved contracts that contain the required language for provider agreements. VUMC is the primary network for VHP, and VHP is 100% owned by VUMC.

4. Failure to file audited financial statements

Finding

VHP failed to file audited financial statements. Section 2-11.i of the contract between VHP and TennCare states that audited financial statements covering the previous calendar year must be submitted by May 1 of each calendar year. VHP requested and was granted two extensions. The first extension deadline was to June 18, 1999, and the second extension was to July 15, 1999. VHP requested a third extension of the deadline. The third extension was denied with permission granted to submit audited statutory financial statements. Audited statutory financial statements have not been filed. As a result of the failure to file audited GAAP and/or audited statutory financial statements, VHP is not in compliance with the TennCare contract and timely information is not available.

Recommendation

VHP should comply with the TennCare contract and file audited financial statements.

Management's Comment

As management has discussed with the Department of Commerce and Insurance and the Bureau of TennCare, VHP has been unable to get KPMG to release the 1998 audited statements. The issues which are causing the delay by KPMG are not related to TennCare or the VHP HMO, but instead are related to Health 1-2-3 and the Commercial Line of Business.

VHP is the parent company of Health 1-2-3 (Commercial & Medicare HMO) and Vanderbilt Management Services ("VMS") (management company for VHP and Health 1-2-3). As a result of this parent/subsidiary relationship, all issues which affect either or both Health 1-2-3 and VMS are reported by and have a direct effect on VHP.

Management is working with KPMG to resolve the outstanding issues on Health 1-2-3 which, in turn, will allow the 1998 audit report for VHP and subsidiaries to be released.