

**Memphis Managed Care Corporation
d/b/a TLC Family Care Healthplan**

**For the Period
January 1, 1998, Through December 31, 1999**

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STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
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John G. Morgan
Comptroller

May 16, 2001

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
Mr. Mark Reynolds, Director
Bureau of TennCare
729 Church Street, Fifth Floor
Nashville, Tennessee 37247

Ladies and Gentlemen:

Pursuant to the agreement between the Comptroller of the Treasury and the Department of Health, 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 Memphis Managed Care Corporation, d/b/a TLC Family Care Healthplan, for the period January 1, 1998, through December 31, 1999.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/pn
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State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Audit Report

Memphis Managed Care Corporation

For the Period January 1, 1998, Through December 31, 1999

FINDINGS

Deficiencies in Claims Processing System

MMCC has not fulfilled contract reporting requirements and processing efficiency requirements specified by the TennCare contract (page 7). This finding is repeated from the prior audit.

Deficiencies in Provider Contract Language

MMCC did not include in the provider agreements all requirements specified by the TennCare contract (page 9).

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

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Memphis Managed Care Corporation
For the Period January 1, 1998, Through December 31, 1999

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Memphis Managed Care Corporation
For the Period January 1, 1998, Through December 31, 1999

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 Health 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.

Memphis Managed Care Corporation (MMCC) was organized as a nonprofit organization by its members, the Regional Medical Center at Memphis, and UT Medical Group, Inc.

Memphis Managed Care Corporation was incorporated on August 4, 1993. Effective January 1, 1994, Memphis Managed Care Corporation contracted with the State of Tennessee as a health maintenance organization (HMO) to provide medical services under the newly established TennCare Program. The Memphis Managed Care Corporation's designated name for the TennCare plan is TLC Family Care Healthplan.

At December 31, 1998, the enrollment in the TennCare Program for MMCC was approximately 54,000 members. At December 31, 1999, the enrollment in the TennCare Program for MMCC was approximately 59,000 members.

MMCC 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, 1998, reported \$10,740,549 in plan assets; \$17,718,938 in liabilities; and negative \$6,978,389 net worth. The statement of revenues, expenses, and net worth for TennCare operations for the year ended December 31, 1998, reported total revenues of \$80,911,585; medical expenses of \$78,567,332; and administrative expenses of \$9,560,438, resulting in net loss of \$7,216,185. Revenue comprises \$80,014,494 in capitation fee payments from TennCare; \$577,888 in investment income; and \$319,203 in other revenue. Medical expenses represent 97.1 percent of capitation fee payments from TennCare, and administrative expenses less premium taxes represent 9.8 percent of capitation fee payments from TennCare.

The annual statement for the year ended December 31, 1999, reported \$19,959,342 in plan assets; \$14,922,795 in liabilities; and \$5,019,836 net worth. The statement of revenues, expenses, and net worth for TennCare operations for the year ended December 31, 1998, reported total revenues of \$96,952,693; medical expenses of \$87,822,296; and administrative expenses of \$9,852,851, resulting in net loss of \$722,454. Revenue comprises \$96,424,867 in capitation fee payments from TennCare and \$527,826 in investment income. Medical expenses represent 90.6 percent of capitation fee payments from TennCare, and administrative expenses less premium taxes represent 8.1 percent of capitation fee payments from TennCare.

SCOPE OF THE EXAMINATION

Our examination covers certain financial related requirements of the contract between the state and Memphis Managed Care Corporation, for the period January 1, 1998, to December 31, 1999. 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 Memphis Managed Care Corporation, for the period January 1, 1995, through December 31, 1995, included the following findings:

Failure to Maintain Minimum Equity Requirements

Memphis Managed Care Corporation did not meet the minimum equity requirements of a health maintenance organization.

Deficiencies in Claims Processing System

Memphis Managed Care Corporation did not fulfill contract reporting and processing efficiency requirements. Evidence that uninsured enrollees were provided with an explanation of benefits for copayments and deductibles and that providers were given remittance advices was not provided. All diagnosis codes were not included in claims/encounter data reporting. Duplicate payments were made by the claims processing system.

The findings concerning deficiencies in the claims processing system 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 and provider agreements. These discrepancies are further discussed in the Findings and Recommendations section of the report.

Subsequent material events and corrections affected the reporting of the operations of MMCC for the period January 1, 1998, through December 31, 1999. MMCC's equity at December 31, 1999, was adjusted by the Division of State Audit as follows:

- Adverse Selection amounts accrued for the years ended 1998 and 1999 were adjusted to the actual amount. This results in decreasing total adverse selection receivable at 12/31/99 by \$732,832; decreasing adverse selection revenue for 1999 by \$513,956; and decreasing adverse selection revenue for 1998 by \$218,876.
- Payments totaling \$2,920,602 for 1998 received in 1999 were not recorded as receivables on the 1998 annual statement. On the December 31, 1999, quarterly statement, these 1998 adverse selection payments are recorded as deferred assets. An adjustment for these payments results in an increase to equity at December 31, 1999, of \$2,920,602.
- Provider claims advances of \$90,547 were reclassified as nonadmitted.

The effect of these adjustments will decrease reported equity from \$5,019,838 to \$4,904,259 as of December 31, 1999. MMCC's minimum net worth requirement at December

31, 1999, was \$3,836,436 per the TennCare contract. MMCC is in compliance with the minimum net worth requirements.



**STATE OF TENNESSEE
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Independent Accountant's Report

June 1, 2000

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
Mr. Mark Reynolds, Director
Bureau of TennCare
729 Church Street, Fifth Floor
Nashville, Tennessee 37247

Ladies and Gentlemen:

We have examined management's assertions included in its representation letter dated June 1, 2000, that Memphis Managed Care Corporation complied with the following requirements during the period of January 1, 1998, through December 31, 1999.

- The organization has complied with its contractual duty to provide certain member services to its enrollees such as membership cards, provider directories, assignment of a primary care provider, and information on filing grievances.
- Assets and liabilities are properly classified as "admitted" or "nonadmitted" on the annual National Association of Insurance Commissioners (NAIC) report which is completed on a "statutory basis of accounting" and filed with the state.
- The organization is in compliance with the minimum equity requirements as specified in 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.

June 1, 2000
Page Two

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 Memphis Managed Care Corporation 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 Memphis Managed Care Corporation with specified requirements.

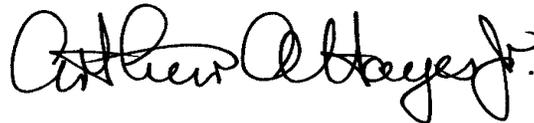
Our examination disclosed the following material noncompliance applicable to Memphis Managed Care Corporation:

- Agreements with subcontractors and with medical providers do not contain the required provisions as specified in the contract with the state.
- The organization is not in compliance with contractual claims processing requirements.
- The organization is not in compliance with contractual reporting requirements.

In our opinion, except for the material noncompliance described in the above paragraph, management's assertions that Memphis Managed Care Corporation complied with the aforementioned requirements for the period January 1, 1998, through December 31, 1999, 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 Health. However, this report is a matter of public record and its distribution is not limited.

Sincerely,

A handwritten signature in black ink that reads "Arthur A. Hayes, Jr." with a stylized flourish at the end.

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

AAH/pn

FINDINGS AND RECOMMENDATIONS

1. Deficiencies in claims processing system

Finding

Memphis Managed Care Corporation did not fulfill contract reporting requirements and processing efficiency requirements. A review of 60 claims for services provided from January 1, 1998, through December 31, 1999, revealed the following:

- a) MMCC 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 60 claims examined had the following time lags:

16 claims within 30 days (26.67% of the 60 claims examined)
13 claims within 31 to 40 days (21.67%)
13 claims within 41 to 60 days (21.67%)
18 claims over 60 days (30%)

- b) Three claims were not paid in agreement with the negotiated rate.
- c) The paper claims could not be located for 2 claims.
- d) Ten claims did not have all the diagnoses codes recorded in the claims processing system.
- e) Copies of explanations of benefits were not supplied for 18 claims.
- f) Three claims were incorrectly denied.
- The denial based on eligibility for 2 claims was inaccurate.
 - One claim was incorrectly denied as provider ineligible.
- g) One claim was not denied for all valid reasons.
- h) The claims processing system does not appear to accurately accumulate out-of-pocket amounts.
- i) Explanations of benefits are not provided to enrollees with coinsurance responsibilities.

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

Recommendation

MMCC should adhere to contract reporting requirements and processing efficiency requirements for claims processing. Claims should be paid according to the correct fee schedule or contract pricing methodologies. All date elements required for individual encounter/claims data reporting should be recorded from claims submitted by providers. All possible reasons for denial should be communicated to the provider. Claims should be paid or denied in the time required by the TennCare contract. Out-of-pocket expenses should be accurately accumulated. Enrollees with coinsurance responsibilities should receive explanations of benefits.

Management's Comment

MMCC has reviewed the findings of the State examination of TLC as they relate to claims processing efficiency requirements. Since that review, TLC has taken steps to correct and closely monitor its claims processing operations. During the audit, nine separate deficiencies were noted. We will respond to each in turn.

- (A) MMCC did not meet the claims processing requirements specified by the TennCare contract.

Response: To insure the timely adjudication of claims, a "held claims" or aging report is generated each Monday for any claim greater than ten days old. The held claims report is given to an assigned adjudicator for completion. That adjudicator must complete the processing of those claims prior to processing any new claims. Where a claim is not capable of being fully processed by the adjudicator, it is then forwarded to the claims manager or designee for follow-up and/or completion.

- (B,F,G) Three claims were not paid in agreement with the negotiated rate; three claims were incorrectly denied; one claim was not denied for all valid reasons.

Response: New policies and procedures have been drafted and are awaiting Plan approval. Once approved, these policies and procedures will be utilized to train claims adjudicators on various issues, including among other things, valid reasons for denying a claim.

- (C) The paper claims could not be located for two claims.

Response: MMCC is presently exploring its options relating to claims scanning and/or micrographics software. This will enable the health plan to scan and/or image all incoming claims and copies could be produced upon request.

- (D) Ten claims did not have all of the diagnosis codes recorded in the claims processing system.

Response: It is the policy of TLC to have its Informations Systems Department, by mid-February of each year, receive and load all new additions and deletions as it pertains to ICD-9 coding. These codes are then re-checked by the Benefits Administrator of the health plan to ensure accuracy and availability.

- (E,I) Copies of explanations of benefits were not supplied for 18 claims; explanations of benefits are not provided to enrollees with coinsurance responsibilities.

Response: Effective January 2001, explanation of benefits is being provided to members with coinsurance responsibilities. Also, copies of explanation of benefits are available upon request.

- (H) The claims processing system does not appear to accurately accumulate out-of-pocket amounts.

Response: In June 2000, TLC began testing its claims processing system to determine whether out-of-pocket amounts were accumulating accurately. All system Medical Definitions, Benefits Rules, and Benefits Packages were reworked and restructured. As of August 2000, the out-of-pocket accumulation process is functional and accurately accumulating all expenses.

2. Deficiencies in provider contract language

Finding

Memphis Managed Care Corporation did not comply with the TennCare contract requirements for provider agreements. The contracts did not contain all requirements as specified in Section 2-18 of the contract between TennCare and Memphis Managed Care Corporation. Language describing the following requirements is excluded or deficient in contracts between MMCC and its providers:

- Specify that the provider may not refuse to provide medically necessary or covered preventive services to a TennCare patient for non-medical reasons, including, but not limited to, failure to pay applicable deductibles, copayments, and/or special fees. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;
- The Contractor shall submit the proposed arbitration procedure, existing alternative arbitration procedure, or any subsequent modification to the arbitration procedure to the Tennessee Department of Commerce and Insurance, TennCare Division for review and approval/denial within 30 calendar days after receipt. If a modification to the arbitration procedure is sent, it shall be sent Certified Mail-Return Receipt Requested.

- Specify that the provider shall be required to accept TennCare reimbursement amounts for services provided under the agreement between the provider and the MCO 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 MCO;
- The provider shall have at least 120 calendar days from the date of rendering a health care service to file a claim and no more than 180 calendar days to file an initial claim with the MCO.
- Enrollees have the right to appeal adverse decisions that affect services. Notices of the right to appeal adverse decisions shall be displayed by the provider in public areas of the providers' facility(s).
- At the next renewal, but no later than December 31, 1998, require that if any requirement in the provider agreement is determined by TENNCARE to conflict with the Agreement between TENNCARE and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect; and
- All provider agreements must include language which informs providers of the package of benefits that EPSDT offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. For existing provider agreements, this may be accomplished at the next renewal, but no later than December 31, 1998.

Recommendation

MMCC 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. All subcontracts should be approved by the TennCare Bureau.

Management's Comment

TLC performed a review of our Provider Agreements ("Agreements") in mid-2000 and determined that many of these contracts did not contain the most recent required language by the Bureau of TennCare ("Bureau"). TLC is in the process of redrafting all of our Agreements and submitting those agreements to the Tennessee Department of Commerce and Insurance for approval. Concurrently, TLC is recontracting with all of its providers using these new Agreements, and plans to complete this recontracting effort by July 1, 2001. TLC has also established a process to amend those Agreements as any new required language is established by the Bureau in the future to ensure the Agreements remain in compliance.