

OmniCare Health Plan, Inc.

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

Arthur A. Hayes, Jr., CPA, JD, CFE
Director

Ronald M. Paolini, CPA
Assistant Director

Clare A. Tucker, CPA
Audit Manager

Karen Degges
In-Charge Auditor

Beth Pugh
Tammy Farley
Staff Auditors

Amy Brack
Editor

Comptroller of the Treasury, Division of State Audit
1500 James K. Polk Building, Nashville, TN 37243-0264
(615) 401-7897

TennCare/Medicaid audits are available on-line at www.comptroller.state.tn.us/sa/reports/index.html.
For more information about the Comptroller of the Treasury, please visit our Web site at
www.comptroller.state.tn.us.



STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

State Capitol
Nashville, Tennessee 37243-0260
(615) 741-2501

John G. Morgan
Comptroller

December 27, 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 OmniCare Health Plan, Inc., for the period January 1, 1998, through December 31, 1999.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/pn
01/010

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Audit Report

OmniCare Health Plan, Inc.

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

Deficiencies in Claims Processing System

OmniCare has not fulfilled contract reporting requirements and processing efficiency requirements specified by the TennCare contract (page 6).

Deficiencies in Provider Contract Language

OmniCare did not include in the provider agreements all requirements specified by the TennCare contract (page 7).

"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

Comptroller of the Treasury, Division of State Audit
1500 James K. Polk Building, Nashville, TN 37243-0264
(615) 401-7897

TennCare/Medicaid audits are available on-line at
www.comptroller.state.tn.us/sa/reports/index.html.
For more information about the Comptroller of the Treasury, please visit our Web site at
www.comptroller.state.tn.us.

OmniCare Health Plan, Inc.
For the Period January 1, 1998, Through December 31, 1999

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
Purpose and Authority of the Examination	1
Background	1
Scope of the Examination	2
Prior Examination Findings	3
Results of the Examination	3
Independent Accountant's Report	4
FINDINGS AND RECOMMENDATIONS	6
1. Deficiencies in claims processing system	6
2. Deficiencies in provider contract language	7

OmniCare Health Plan, Inc.
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 Health 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.

OmniCare Health Plan, Inc., (OmniCare) was chartered in the State of Tennessee in October 1993. The ownership of OmniCare consists of a 75% interest by United American of Tennessee (UAT) and a 25% interest held by Mr. Alvin King. UAT is a wholly owned subsidiary of United American Healthcare Corporation. Effective January 1, 1994, OmniCare Health Plan, Inc., contracted with the State of Tennessee as a preferred provider organization

(PPO) to provide medical services under the newly established TennCare Program. Effective March 1, 1996, OmniCare no longer contracted as a PPO but as a health maintenance organization (HMO). At December 31, 1998, the enrollment for the plan was approximately 42,000 members and at December 31, 1998, approximately 46,000 members.

OmniCare 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 \$17,543,613 in plan assets; \$14,599,635 in liabilities; and \$2,943,978 net worth. The statement of revenues, expenses, and net worth for TennCare operations for the year ended December 31, 1998, reported total revenues of \$68,185,344; medical expenses of \$56,554,585; and administrative expenses of \$12,017,773, resulting in net loss of \$387,013. Revenue comprises \$67,246,228 in capitation fee payments from TennCare; \$777,247 in investment income; and \$161,869 in other revenue. Medical expenses represent 84.1% of capitation fee payments from TennCare, and administrative expenses less premium taxes represent 15.8% of capitation fee payments from TennCare.

The annual statement for the year ended December 31, 1999, reported \$19,096,168 in plan assets; \$13,619,233 in liabilities; and \$5,476,935 net worth. The statement of revenues, expenses, and net worth for TennCare operations for the year ended December 31, 1999, reported total revenues of \$73,597,421; medical expenses of \$59,122,456; and administrative expenses of \$11,911,500, resulting in net income of \$2,563,465. Revenue comprises \$72,345,306 in capitation fee payments from TennCare; \$919,788 in investment income; and \$332,327 in other revenue. Medical expenses represent 81.8% of capitation fee payments from TennCare, and administrative expenses less premium taxes represent 14.5% of capitation fee payments from TennCare.

SCOPE OF THE EXAMINATION

Our examination covers certain financial related requirements of the contract between the state and OmniCare Health Plan, Inc., 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 OmniCare Health Plan, Inc., for the period January 1, 1996, through December 31, 1997, included the following findings:

Lack of Internal Controls in the Mailroom

Claims submitted by medical providers were not date-stamped on the date of receipt. The date received as recorded in the claims processing system did not agree with the date stamped on the claim. No reconciliation was performed to ensure all claims received had been processed.

Deficiencies in Claims-Processing System

OmniCare Health Plan, Inc., did not adhere to contract reporting requirements and processing efficiency requirements. Emergency room claims were improperly denied. All data elements required for individual encounter/claims data reporting were not accurately recorded from claims providers submitted. An electronic billing option was not offered to OmniCare's contracted providers.

Deficiencies in Financial Reporting

The annual statement for the year ended December 31, 1997, contained material misstatements. Receivables were improperly recorded as a reduction of medical payables on the annual statement. Receivables of \$864,499 should not have been included in the calculation of statutory equity. Medical expenses were underreported by \$114,414 on the annual statement.

Deficiencies in Provider Agreements

OmniCare Health Plan, Inc., 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 and provider agreements. These discrepancies are further discussed in the Findings and Recommendations section of the report.

OmniCare is in compliance with the minimum net worth requirements at December 31, 1999.



**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
DEPARTMENT OF AUDIT
DIVISION OF STATE AUDIT
SUITE 1500
JAMES K. POLK STATE OFFICE BUILDING
NASHVILLE, TENNESSEE 37243-0264
PHONE (615) 401-7897
FAX (615) 532-2765**

Independent Accountant's Report

August 31, 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 August 31, 2000, that OmniCare Health Plan, Inc., 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.

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 OmniCare Health Plan, 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 OmniCare Health Plan, Inc., with specified requirements.

Our examination disclosed the following material noncompliance applicable to OmniCare Health Plan, Inc.:

- 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 OmniCare Health Plan, Inc., 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

OmniCare Health Plan, Inc., 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) OmniCare 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:

23 claims within 30 days (38% of the 60 claims examined)

12 claims within the 31 to 40 days (20%)

16 claims within 41 to 60 days (27%)

9 claims over 60 days (15%)

- b) During the audit period, OmniCare did not offer electronic billing to its providers.
- c) Five claims were not paid in agreement with the negotiated rate. The incorrect fee schedule was used.
- d) Three claims did not have all common and provider-specific data elements recorded in the claims processing system.
- e) Explanations of benefits for five claims could not be provided.
- f) Four claims were incorrectly denied based on timely filing.
- g) One claim was paid when it should have been denied. A keying error put the claim in the system under the wrong member number.
- h) One claim was denied when it should have been paid. A keying error put the claim in the system under the wrong member number.

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

Recommendation

OmniCare 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.

Management's Comment

Management did not respond to this finding.

2. Deficiencies in provider contract language

Finding

OmniCare Health Plan, Inc., 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 OmniCare Health Plan, Inc. Language describing the following requirements is excluded or deficient in contracts between OmniCare 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;
- Require that any and all records be maintained for a period not less than five (5) years from the close of the agreement and retained further if the records are under review or audit until the review or audit is complete. Said records shall be made available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of authorized representative of the MCO or TennCare;
- Require that the provider comply with corrective action plans initiated by the MCO;
- Provide for payment within thirty (30) calendar days to the provider upon receipt of a clean claim properly submitted by the provider;

- Specify the provider shall accept payment or appropriate denial made by the MCO (or, if applicable, payment by the MCO 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;
- Specify that the provider must adhere to the Quality of Care Monitors included in the Agreement as Attachment IV;
- Specify that the provider will comply with the grievance process including but not limited to assisting an enrollee by providing appeals forms and contact information including the appropriate address for submitting appeals for state level review;
- 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

OmniCare 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

Management did not respond to this finding.