

**HERITAGE NATIONAL HEALTHPLAN OF
TENNESSEE, INC.
TENNCARE OPERATIONS**

**FOR THE PERIOD
JANUARY 1 THROUGH DECEMBER 31, 1994**

Arthur A. Hayes, Jr., CPA

Director

Ronald M. Paolini, CPA

Assistant Director

Clare Tucker, CPA

Audit Manager

John R. Mattingly, CPA

In-Charge Auditor

Julie Criner

Anne Oakes, R.N.

Faye Simmerly, R.N.

Malinda Wilhoit

Staff Auditors

Leslie Bethea

Editor

July 1, 1996

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
and
The Honorable Bob Corker, Commissioner
Department of Finance and Administration
and
Members of the State Insurance Committee
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the report on the compliance audit of the managed care organization (MCO) Heritage National Healthplan of Tennessee, Inc., TennCare Operations, for the period January 1 through December 31, 1994.

The review of the operations disclosed certain deficiencies, which are detailed in the Finding and Recommendation section of this report. This report is intended to aid the Bureau of TennCare in its review to determine whether the MCO has adhered to the terms of the health maintenance organization contract. The Department of Commerce and Insurance should take whatever action it deems appropriate regarding the finding contained in this report.

Very truly yours,

W. R. Snodgrass
Comptroller of the Treasury

cc: Bill Young
Theresa Clarke

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Compliance Audit

Heritage National Healthplan of Tennessee, Inc.

TennCare Operations

For the Period January 1 through December 31, 1994

AUDIT OBJECTIVES

The objectives of the audit were to determine if the managed care organization (MCO) is meeting its contractual obligations, including, but not limited to, proper claims payment, proper accounting for payments from the TennCare Bureau, proper enrollment counts, maintenance of sufficient financial reserves, and recordkeeping sufficient to meet program requirements.

AUDIT FINDING

Deficiency in Claims Processing System

Heritage National Healthplan of Tennessee, Inc., did not record all procedure codes and charges for certain claims for medical services (page 5).

"Audit Highlights" is a summary of the 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) 741-3697

COMPLIANCE AUDIT
HERITAGE NATIONAL HEALTHPLAN OF TENNESSEE, INC.
TENNCARE OPERATIONS
FOR THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 1994

TABLE OF CONTENTS

	<u>Page</u>
<u>INTRODUCTION</u>	1
Purpose of the Audit	1
Post-Audit Authority	1
Scope of the Audit	2
<u>BACKGROUND INFORMATION</u>	2
<u>RESULTS OF THE AUDIT</u>	4
Finding and Recommendation	5
• Deficiency in claims processing system	5

COMPLIANCE AUDIT
HERITAGE NATIONAL HEALTHPLAN OF TENNESSEE, INC.
TENNCARE OPERATIONS
THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 1994

INTRODUCTION

PURPOSE OF THE AUDIT

This report details the results of a compliance audit of the transactions, books, and accounts of Heritage National Healthplan of Tennessee, Inc., TennCare Operations. The purpose of this audit was to evaluate the programmatic operations of the managed care organization (MCO) in accordance with generally accepted government auditing standards and to determine if Heritage National Healthplan of Tennessee, Inc., TennCare Operations, was administered in accordance with the requirements of *Tennessee Code Annotated* and the contracts between the state and the MCO. The objectives of the audit were

1. to determine whether the MCO is meeting its contractual obligations under the TennCare agreement with the state;
2. to determine whether the MCO has properly adjudicated claims from service providers and has made payments in a timely manner;
3. to determine whether enrollment counts and categories are accurate and whether monthly payments and withhold amounts from TennCare to the MCO are accurate;
4. to determine if the MCO has sufficient financial capital to ensure uninterrupted delivery of health care;
5. to determine if records maintained by the MCO are adequate to determine compliance with the rules and contract requirements of the Bureau of TennCare; and
6. to recommend appropriate actions to correct any deficiencies.

POST-AUDIT AUTHORITY

This audit was conducted pursuant to Section 4-3-304, *Tennessee Code Annotated*, which authorizes the Department of Audit to “perform a post-audit of all accounts and other financial records of the state government and of any department, institution, office, or agency thereof in

accordance with generally accepted auditing standards and in accordance with such procedures as may be established by the comptroller.”

Section 8-4-109, *Tennessee Code Annotated*, authorizes the Comptroller of the Treasury to audit any books and records of any government entity that handles public funds when the Comptroller considers an audit to be necessary or appropriate. In addition, Section 2-14 of the Contractor Risk Agreement between Heritage National Healthplan of Tennessee, Inc., TennCare Operations, and the State of Tennessee provides that the books and records “shall be available for review by authorized federal, state, and Comptroller personnel.”

SCOPE OF THE AUDIT

The audit examined the records, transactions, and contract provisions of Heritage National Healthplan of Tennessee, Inc., TennCare Operations, for the period January 1 through December 31, 1994. The audit included tests of insurance claims, review of accounting records, and other auditing procedures considered necessary.

BACKGROUND INFORMATION

Effective January 1, 1994, the State of Tennessee received approval from the U.S. Department of Health and Human Services to begin a five-year Medicaid waiver project which changed most services covered under the Medicaid program to a managed care capitated system. Under the waiver program, known as TennCare, the state contracts with 12 managed care organizations that manage and provide care for enrollees for a stated monthly capitation fee. In addition to recipients eligible under Medicaid criteria, certain uninsured or uninsurable persons may enroll in the TennCare Program. The managed care organizations 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.

The Tennessee Department of Finance and Administration is the state agency responsible for administration of the managed care program in Tennessee. The department is authorized to contract with MCOs to provide specified services to people who are or would have been eligible for Medicaid as it was administered during fiscal year 1992-93 and to other Tennesseans who are eligible for and are enrolled in the TennCare system. The managed care organization must

1. be appropriately licensed to operate within the State of Tennessee;
2. demonstrate the existence of a network of health care providers capable of providing comprehensive health care services throughout the community where the plan is offered;

3. clearly demonstrate the capability and intent to provide case management services;
4. assure the availability of service providers outside the community service network for covered services that are not commonly provided in that particular community area;
5. demonstrate sufficient financial capital to ensure uninterrupted delivery of health care on an ongoing basis;
6. demonstrate sufficient financial capital, network capability, and a willingness to accept a reasonable number of enrollees from any failed health plan operating in the community;
7. agree to move to electronic billing for all of its TennCare plans within three years of the effective date of the agreement;
8. unanimously agree with other MCOs in the TennCare system for the provision of pharmacy services to TennCare enrollees who reside in long-term care facilities so that only one pharmacy shall be responsible for their pharmacy services;
9. agree not to require service providers to accept TennCare reimbursement amounts for services provided under any non-TennCare plan operated or administered by the managed care organization; and
10. mutually agree to such other requirements as may be reasonably established by TennCare.

Heritage National Healthplan of Tennessee, Inc., is a wholly owned subsidiary of John Deere Health Care, Inc., which is a wholly owned subsidiary of Deere & Company. Effective January 1, 1994, Heritage National Healthplan of Tennessee, Inc., contracted with the State of Tennessee as a health maintenance organization (HMO) to provide medical services under the newly established TennCare program. At December 31, 1994, the enrollment for the plan was approximately 28,000.

As a HMO, Heritage National Healthplan of Tennessee, Inc., files quarterly and annual statements with the Department of Commerce and Insurance. The department uses the information in these reports to determine if the health maintenance organization 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 assets must be easily converted to cash to pay for outstanding claims. Assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and are reduced from equity. The plan maintains a restricted deposit of \$1,283,217 to satisfy requirements of the Department of Commerce and Insurance. As of December 31, 1994, the plan reported \$39,366,194 in assets, \$31,871,132 in liabilities, and \$7,495,062 in equity. Heritage National Healthplan of Tennessee,

Inc., TennCare Operations, reported total revenues of \$34,557,783 and total expenses of \$34,593,453, producing an operating loss before taxes of \$35,670 for the period January 1 through December 31, 1994. Revenue consists entirely of capitation fee payments and other reimbursements from TennCare. Heritage National Healthplan of Tennessee, Inc., TennCare Operations, reported \$28,606,480 in medical expenses and \$5,986,973 in administrative expenses.

This is the first audit of the provisions of the health maintenance organization contract between the State of Tennessee and Heritage National Healthplan of Tennessee, Inc.

RESULTS OF THE AUDIT

Our review of the plan revealed discrepancies in the claims processing system. These discrepancies are further discussed in the Finding and Recommendation section of the report. Our review of the plan's accounting and financial data revealed no discrepancies.

Subsequent material events affected the financial reporting of the Heritage National Healthplan of Tennessee, Inc., TennCare Operations, for the period January 1 through December 31, 1994. A final accounting by the Bureau of TennCare in September 1995 resulted in additional money to be received for the audit period for adverse selection, retroactive adjustments, and reimbursement for the first month of uninsured coverage. The net effect of these events was to increase TennCare premium revenue by \$1,848,536. Also, premium tax expense and management fee expense should be increased by \$63,689 and \$277,280, respectively. If the financial reporting for Heritage National Healthplan of Tennessee, Inc., for the audit period were adjusted, the net income before applicable taxes would be increased \$1,507,567. Heritage National Healthplan of Tennessee, Inc., appears to have sufficient capital to ensure uninterrupted delivery of health care.

FINDING AND RECOMMENDATION

DEFICIENCY IN CLAIMS PROCESSING SYSTEM

FINDING:

Heritage National Healthplan of Tennessee, Inc., did not comply with the TennCare Bureau's requirements regarding encounter data for 1994. The claims processing system did not record all procedure codes and charges for certain claims for medical services.

Section 2-11(f) of the contract between TennCare and Heritage National Healthplan of Tennessee, Inc., requires that encounter data be reported in a format specified by TennCare. Additionally, Attachment II, Exhibit E, of the contract lists procedure codes and charges as required data elements for claims/encounter data reporting.

RECOMMENDATION:

Heritage National Healthplan of Tennessee, Inc., should comply with the TennCare Bureau's requirements regarding encounter data. The claims processing system should record all procedure codes and charges for claims for medical services.

MANAGEMENT'S COMMENT:

JOHN DEERE HEALTH CARE, INC. (JDHC) REASONING BEHIND "METHOD B" PROCESSING:

When all surgical procedures are on the fee schedule, the payment is made on the surgical lines only.

When there are more than six lines of service and only one surgical CPT code on the claim, this results in denied EOBs that are generated separately from the payment Voucher. Thus, the facility receiving payment is confused when the EOBs are generated daily and the payment Vouchers are generated weekly. Frequently the denied EOBs are received by the provider of service several days before the payment Voucher, and then only a portion of the charges are reflected.

The Enrollee also receives copies of the denied EOBs; however, they do not receive any notification of the payment portion of the claim.

JDHC'S ACTION PLAN/PROPOSAL:

All charges and procedure codes will be coded as billed, which will generate the denied EOBs to the provider(s) of service as well as to the enrollee; however, the payment Voucher is sent to the provider of service only. The enrollee will not receive notification of the segment(s) that create a payment.

The provider of service will have to combine the denied EOBs with the payment Voucher, when it is received, to calculate the full JDHC benefit.

COST FOR ADDITIONAL EOBs THAT WILL BE GENERATED:

The approximate cost per EOB is \$.50.

The average amount of segments created from a surgical hospital claim is two or three.

This will create four to six EOBs (two to three to the provider and the same amount to the Enrollee) per claim, and one payment Voucher to the provider of service.

SAMPLE JDHC FOR 1996 "METHOD B" CLAIMS THAT WILL NEED TO BE ADJUSTED:

There were a total of 310 surgical claims for the time period of 1/1/96 through 6/7/96.

There are approximately 165 claims for 1/1/96 through 6/7/96 that would have to be adjusted to comply with TennCare's requirements.

ACTION PLAN 1996

We will adjust all claims since 1/1/96 and pay according to data given on claim. Method B Processing will be discontinued for TennCare. Adjustments should be completed within the next four weeks.

TennCare will see corrections on their monthly report ran by T. Watkins.