

**HEALTHSOURCE TENNESSEE, INC.
D/B/A TENNSOURCE**

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

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July 15, 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) Healthsource Tennessee, Inc., d/b/a Tennsource, for the period January 1 through December 31, 1994.

The review of the operations disclosed certain deficiencies, which are detailed in the Findings and Recommendations 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 preferred provider organization contract. The Department of Commerce and Insurance and the Department of Finance and Administration should take whatever action it deems appropriate regarding the findings 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
Healthsource Tennessee, Inc.
d/b/a Tennsource
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 FINDINGS

Inadequate Accounting System and Deficiencies in Financial Reporting

Healthsource Tennessee, Inc., has not developed an adequate accounting system for TennCare operations. An additional \$255,954 in revenue earned in 1994 and received in 1995 should have been included for the period January 1 through December 31, 1994 (page 7).

Deficiencies in Claims Processing System

Healthsource Tennessee, Inc., has not fulfilled contract reporting requirements and processing efficiency requirements. Deductibles and copayments for certain claims for medical services were incorrectly computed. Also, weekly claims processing reports are not in compliance with contract requirements (page 8).

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

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COMPLIANCE AUDIT
HEALTHSOURCE TENNESSEE, INC.
d/b/a TENNSOURCE
FOR THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 1994

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COMPLIANCE AUDIT
HEALTHSOURCE TENNESSEE, INC.
d/b/a TENNSOURCE
FOR 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 Healthsource Tennessee, Inc., d/b/a Tennsource. 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 Healthsource Tennessee, Inc., 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 Healthsource Tennessee, Inc., 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 Healthsource Tennessee, Inc., d/b/a Tennsource, 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.

Healthsource Tennessee, Inc., and Healthsource Tennessee Preferred, Inc., are wholly owned subsidiaries of Healthsource Management, Inc. Healthsource Management, Inc., is a wholly owned subsidiary of Healthsource, Inc., a publicly traded corporation. From January 1, 1994, through July 31, 1994, TennCare operations, d/b/a Tennsource, were managed through Healthsource Tennessee, Inc. Thereafter Tennsource is managed by Healthsource Tennessee Preferred, Inc. Effective January 1, 1994, Healthsource Tennessee, Inc., contracted with the State of Tennessee as a preferred provider organization (PPO) to provide medical services under the newly established TennCare program. At December 31, 1994, the enrollment for the plan was approximately 5,400 members.

As a PPO, Tennsource, the TennCare operations of Healthsource Tennessee, Inc., must establish risk reserves in an amount equal to what would have been required by the Tennessee Department of Commerce and Insurance if Tennsource had been a health maintenance organization licensed by the State of Tennessee. Also, Tennsource is allowed to retain up to 10 percent of the monthly capitation amount paid by TennCare as a management fee, with the remainder of the monthly capitation payment available for the payment of covered benefits. TennCare shall not be liable for any excess benefit costs. Any and all excess administrative costs will be borne by

Tennsource. In the event of savings, Tennsource, as provided for in Section 2-10(e)(2) of the TennCare contract, is required to share with TennCare a portion of such savings after medical benefits and allowable administrative expenses are paid. The contractor shall be permitted to share 5 percent of the savings with the providers. The contractor shall be allowed to retain 5 percent for the contractor's efficiency. The remainder of the savings shall be returned to TennCare.

This is the first audit of the provisions of the preferred provider organization contract between the State of Tennessee and Healthsource Tennessee, Inc.

RESULTS OF THE AUDIT

Our review of the plan's claims processing system and accounting and financial data revealed discrepancies which are further discussed in the Findings and Recommendations section of the report.

Based on our audit, the capitation payments by TennCare, and the payments by Tennsource, we have computed a plan savings of \$353,892 for the year ended December 31, 1994. Schedule 1 exhibits the tentative settlement calculation according to the Division of State Audit. A final settlement will be determined when all transactions for the period under audit have been completed.

SAVINGS CALCULATION AND TENTATIVE SETTLEMENT
FOR THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 1994
PREPARED BY THE DIVISION OF STATE AUDIT

Capitation Amounts Paid by TennCare for 1994 Dates of Eligibility:

Payments by TennCare for FYE 12/31/94 Enrollment	\$5,944,632	
Adverse Selection Capitation for 1994	813	
Retroactive Capitation Adjustment for 1994	<u>258,989</u>	
Total Capitation Adjustment for 1994 Dates of Eligibility		\$6,204,434
Less: Management Fee (10%)		<u>620,443</u>
Available for Payment of Covered Services		5,583,991
<u>Less: Payments by Tennsource for Covered Benefits:</u>		
Cash Payments January 1, 1994, through February 14, 1996, for January 1 through December 31, 1994, Services		<u>5,230,099</u>
<u>Total Savings</u>		<u><u>\$ 353,892</u></u>

Distribution of Savings:

Due to TennCare (90%)	\$ 318,503
Available to Providers (5%)	17,695
Available to Healthsource Tennessee, Inc. (5%)	<u>17,695</u>
Total Distribution of Savings	<u><u>\$ 353,892</u></u>

The savings calculation as computed is a tentative settlement pending disposition of the following issues:

- Tennsource has suspended \$562,950 in payments for covered benefits. These payments were suspended by Tennsource because it had determined payments for covered benefits had reached 90% of the capitation received from TennCare.
- TennCare is withholding \$261,103 in capitation payments for 1994 eligibility due to Tennsource because of noncompliance with encounter data reporting requirements (see finding 2).

The department of Finance and Administration should take appropriate action to collect the savings due to the state.

From the audited financial statements of Healthsource Tennessee, Inc., the TennCare schedule of operating information reported total revenues of \$5,948,479, medical and hospital expenses of \$5,485,858, administrative expenses of \$790,904, and an operating loss of \$328,283 for the period January 1, 1994, through December 31, 1994. From a balance sheet compiled for Tennsource, total assets were reported as \$1,418,965 and total liabilities were reported as \$1,747,248; and a retained deficit of \$328,283 was reported. The consolidated stockholders deficit for Healthsource Tennessee, Inc., was reported as \$25,890. Included in the audited financial statements for Healthsource Tennessee, Inc., is long-term payables of \$3,900,000 consisting of subordinated surplus debentures due to related parties. Payment of these payables is subordinated to the claims of healthcare providers under contract with the company and requires the approval of the Commissioner of Commerce and Insurance of the State of Tennessee. The conversion of these payables into equity allows Healthsource Tennessee, Inc., to achieve minimum equity requirements.

Subsequent material events and the improper accounting for revenues affected the reporting of the operations of Tennsource for the audit period. A final accounting by the Bureau of TennCare in September 1995 resulted in differences for reported 1994 estimates of money to be received for retroactive capitation adjustments and adverse selection. The net effect of these events was to increase TennCare revenue and TennCare receivables by \$255,954. Also, premium tax expense and payable should be increased by \$3,719. Medicaid expenses should be adjusted to actual payments of \$5,230,099, and an additional expense of \$336,197 should be recognized for the savings distribution. If the 1994 TennCare schedule of operating information were adjusted, the loss for the plan would be \$156,486.

FINDINGS AND RECOMMENDATIONS

INADEQUATE ACCOUNTING SYSTEM AND DEFICIENCIES IN FINANCIAL REPORTING

1. FINDING:

Healthsource Tennessee, Inc., has not developed an adequate accounting system for TennCare operations. The accounting system should produce a general ledger composed of journal entries supported by documentation of payments. The general ledger balances at fiscal year-end should be reported on a trial balance.

Healthsource Tennessee, Inc., reported TennCare operations by accumulating cash receipts and payments for the period January 1 through December 31, 1994, and ad-justed for unpaid withholds from TennCare and unpaid expenses at December 31, 1994.

As a result of the inadequate accounting system, TennCare revenues were understated by \$255,954 for the period January 1 through December 31, 1994.

RECOMMENDATION:

Healthsource Tennessee, Inc., should develop an adequate accounting system for TennCare operations. An acceptable accounting system should produce a trial balance at fiscal year-end supported by a general ledger. The general ledger should contain journal entries supported with documentation of payments and accruals. Revenues should be reported in the year earned.

MANAGEMENT'S COMMENT:

We believe that we have taken steps to address this deficiency. The company is currently implementing a new computer system that should be in place by August 1996. The deficiency as described above has been addressed in conversion planning meetings, and steps to correct are in progress. With this conversion in place, we will have the ability to produce a separate TennSource trial balance that is supported by a general ledger. The \$255,954 mentioned as an audit adjustment relates to a payment received in 1995 subsequent to the closing of the 1994 books. When the payment was identified, we agreed that it should be reclassified back to 1994. We are also actively pursuing the transition of TennSource into a full risk HMO arrangement. This will also enable us to produce more accurate and timely financials.

DEFICIENCIES IN CLAIMS PROCESSING SYSTEM

2. FINDING

Healthsource Tennessee, Inc., has not fulfilled contract reporting requirements and processing efficiency requirements for TennCare operations. Our review noted the following problems:

- Healthsource Tennessee, Inc., did not comply with the TennCare Bureau's requirements regarding encounter data for 1994. Healthsource Tennessee, Inc., submitted encounter data that was considered unacceptable. As a result, the TennCare Bureau notified Healthsource Tennessee, Inc., that the 10% capitation withhold amount would be retained. Encounter data, a record of the medical services provided to enrollees, is necessary for evaluation of quality of care and access to TennCare services. The claims processing system did not record all revenue codes and charges from claims for medical services. Section 2-11(f) of the contract between TennCare and Healthsource Tennessee, Inc., requires that encounter data be reported in a format specified by TennCare. Additionally, Attachment II, Exhibit E, lists revenue codes as required data elements for claims/encounter data reporting. As a result of the failure to comply with encounter data reporting, the Bureau of TennCare is withholding \$269,103.09 in capitation payments for 1994. Additionally, 10% of the capitation payments for 1995 are withheld from capitation payments to Healthsource Tennessee, Inc., until the encounter data is submitted in the required format.
- Healthsource Tennessee, Inc., incorrectly calculated deductibles and copayments related to certain TennCare claims paid based upon percent of charges. The deductibles and copayments were computed based on the charges for medical services instead of the negotiated rate between the hospitals and Healthsource Tennessee, Inc. Section 2-3(h) of the TennCare contract with Healthsource Tennessee, Inc., states, "Deductibles and copayments charged the enrollee shall be based upon the negotiated rate between the MCO and the provider." As a result of the incorrect calculation, deductibles and copayments were overstated and medical providers were underpaid.
- A sample of TennCare claims processed by Healthsource Tennessee, Inc., revealed an average processing lag of 43 days from the receipt of a claim to its final adjudication. Section 2-18 of the TennCare contract with Healthsource Tennessee, Inc., states, "The Contractor agrees to make payments within thirty calendar days of receipt for at least ninety-five percent of all clean claims." "Clean claims" are claims which do not require additional information from the medical provider before processing.

- Weekly claims processing reports did not report all the required information specified by the contract. Section 2-11(g) of the TennCare contract with Healthsource Tennessee, Inc., defines the information to be reported on a weekly basis to TennCare. The following items should be included in the report:
 - number of unpaid claims in inventory by service type;
 - aging of unpaid claims by service type;
 - average time from receipt to final payment of claim by service type;
 - approximate value of unpaid claims by service type;
 - number of member phone calls; and
 - approximate waiting time for member response.

RECOMMENDATION:

Healthsource Tennessee, Inc., should submit encounter data in the format specified by the Bureau of TennCare. All revenue codes and charges should be included in encounter data reporting. Copayments and deductibles should be computed based on the negotiated rate between Healthsource Tennessee, Inc., and the medical providers. Claims previously paid in error should be recomputed to correctly compute deductibles and copayments based on the negotiated rates. Healthsource Tennessee, Inc., should notify and ensure that providers properly adjust patient accounts for the overstated deductibles and copayments. Healthsource Tennessee, Inc., should adhere to contract guidelines regarding claims processing efficiency and the submission of weekly claims processing reports.

MANAGEMENT'S COMMENT

We have taken measures to address the claims areas which were deficient. According to Section 2-11(g) of the TennCare contract, the weekly report was not produced in a timely manner since last summer. We recreated the data and have now been sending weekly reports. This duty has now been transferred to our new Chattanooga regional operations center. We have been working closely with Jeff Skinner, a programmer from our Corporate office, since January to begin submitting correctly formatted data for reporting requirements. A meeting was held in Nashville on June 5th to further clarify these issues. Representatives from Healthsource Inc., Healthsource North Carolina, as well as our CEO, Steve White, were present. The outpatient tape process has been approved; however, the inpatient process is still in progress. Once identified by the state auditor, we began keying the line item detail on February 14 of this year for all UB92 claims. Section 2-3(h) of the TennCare contract to correctly apply deductibles and copayments has been and will continue to be a manual adjudication through the system by the processors. The system automatically takes the deduct or copay from the billed amount in lieu of the approved amount due to manual calculation of per diem codes/calculations. This process should become an automated process within the new computer system. We have also performed dressage throughout the department, sent files to storage in a secure environment, built the Batch Control Desk to better handle the flow of paper in and out of the department producing a higher level of accountability, and begun stamping each claim with a date received stamp. Due to all of the above, the time to receive and produce a TennCare claim has been greatly improved.