

PHOENIX HEALTHCARE OF TENNESSEE, INC.

**FOR THE PERIOD
JANUARY 1 THROUGH DECEMBER 31, 1995**

Arthur A. Hayes, Jr., CPA

Director

Ronald M. Paolini, CPA

Assistant Director

Clare A. Tucker, CPA

Audit Manager

Karen Degges

In-Charge Auditor

Martha Rogers

Malinda Wilhoit

Staff Auditors

Leslie Bethea

Editor

March 20, 1997

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
and
The Honorable Nancy Menke, Commissioner
Department of Health
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the report on the compliance review of the managed care organization (MCO) Phoenix HealthCare of Tennessee, Inc., for the period January 1 through December 31, 1995.

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 health maintenance organization contract. The Department of Commerce and Insurance should take whatever action it deems appropriate regarding the findings contained in this report.

Very truly yours,

W. R. Snodgrass
Comptroller of the Treasury

WRS/cr
96-126

cc: Bill Young
Theresa Clarke

State of Tennessee

Review Highlights

Comptroller of the Treasury

Division of State Audit

Compliance Review

Phoenix HealthCare of Tennessee, Inc.

For the Period January 1 through December 31, 1995

REVIEW OBJECTIVES

The objectives of the review 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.

REVIEW FINDINGS

Deficiency in Claims Processing System

Phoenix HealthCare of Tennessee, Inc., does not provide uninsured enrollees an explanation of benefits for copayments and deductibles paid (page 5).

Deficiency in Provider Agreements

Phoenix HealthCare of Tennessee, Inc., did not include in provider agreements all requirements specified by the TennCare contract (page 5).

"Review Highlights" is a summary of the report. To obtain the complete review 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 REVIEW
PHOENIX HEALTHCARE OF TENNESSEE, INC.
FOR THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 1995

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COMPLIANCE REVIEW
PHOENIX HEALTHCARE OF TENNESSEE, INC.
FOR THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 1995

INTRODUCTION

PURPOSE OF THE REVIEW

This report details the results of a compliance review of the transactions, books, and accounts of Phoenix HealthCare of Tennessee, Inc. The purpose of this review was to evaluate the programmatic operations of the managed care organization (MCO) and to determine if Phoenix HealthCare of 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 review 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; and
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.

POST-AUDIT AUTHORITY

This review was conducted pursuant to Section 2-14 of the Contractor Risk Agreement between Tennessee Managed Care Network and the State of Tennessee which states:

The CONTRACTOR shall maintain books, records, documents, and other evidence pertaining to the administrative costs and expenses incurred pursuant to this Agreement as well as medical information relating to the individual enrollees for the purposes of audit requirements. Records other than medical records may be kept in original paper state, or preserved on micromedia or electronic format. Medical records shall be maintained in their original form. These records, books,

documents, etc., shall be available for review by authorized federal, state, and Comptroller personnel during the Agreement period and five (5) years thereafter, except if an audit is in progress or audit findings are yet unresolved in which case records shall be kept until all tasks are completed. During the Agreement period, these records shall be available at the CONTRACTOR's chosen location subject to the approval of TENNCARE. If the records need to be sent to TENNCARE, the CONTRACTOR shall bear the expense of delivery. Prior approval of the disposition of CONTRACTOR and subcontractor or provider records must be requested and approved by TENNCARE.

SCOPE OF THE REVIEW

The review examined the records, transactions, and contract provisions of the plan for the period January 1 through December 31, 1995. The review 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 enrollees' care 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 Health 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 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.

Phoenix HealthCare of Tennessee, Inc., a Tennessee corporation, was incorporated on May 20, 1993, by Phoenix HealthCare Corporation, the sole shareholder, 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. On September 10, 1993, Phoenix HealthCare of Tennessee, Inc., was licensed as a health maintenance organization by the State of Tennessee Department of Commerce and Insurance. On November 15, 1993, Phoenix HealthCare of Tennessee, Inc., signed a State of Tennessee TennCare contract that became effective January 1, 1994. At December 31, 1994, the enrollment for the plan was approximately 44,000 members. At December 31, 1995, the enrollment was approximately 36,800 members.

As an HMO, Phoenix HealthCare of Tennessee, Inc., files quarterly and annual statements with the Department of Commerce and Insurance. The department uses the information filed on 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 \$917,000 to satisfy requirements of the Department of Commerce and Insur-

ance. The annual statement for the year ended December 31, 1995, reported \$8,605,120 in plan assets, \$7,074,883 in liabilities, and \$1,530,237 net worth. The annual statement also reported total revenues of \$52,375,721 and total expenses of \$51,983,543, resulting in a net income of \$392,178 for the audit period.

PRIOR REVIEW FINDING:

The previous review of Phoenix HealthCare of Tennessee, Inc., for the year ended December 31, 1994, included the following finding:

Deficiency in Claims Processing System

Phoenix HealthCare of Tennessee, Inc., does not provide uninsured enrollees with an explanation of benefits for copayments and deductibles paid.

This finding will be repeated in the current report (see the Findings and Recommendations section of this report).

SUBSEQUENT MATERIAL EVENTS

Subsequent material events affected the reporting on the annual statement for Phoenix HealthCare of Tennessee, Inc., for the review period. A final accounting by the Bureau of TennCare in December 1996 resulted in differences for reported 1995 estimates of money to be received for adverse selection. TennCare premium revenue and TennCare receivables should be decreased by \$115,463 to adjust adverse selection to the actual amount received. Also, TennCare premium revenue and TennCare receivables should be increased by \$19,027.72 to adjust the capitation rate increase to the actual amount received for 1995. The net effect of these adjustments was to decrease TennCare premium revenue and TennCare receivables by \$96,435.28. If the 1995 annual statement were adjusted, the net income before applicable taxes for the plan would be \$295,742.72, and total net worth for the plan would be \$1,433,801.72. Phoenix HealthCare of Tennessee, Inc., appears to have sufficient capital to ensure uninterrupted delivery of health care.

RESULTS OF THE REVIEW

Our review of the accuracy of claims processing and accounting and financial data reported by Phoenix HealthCare of Tennessee, Inc., revealed discrepancies which are further discussed in the Findings and Recommendations section of the report.

FINDINGS AND RECOMMENDATIONS

DEFICIENCY IN CLAIMS PROCESSING SYSTEM

1. FINDING:

Phoenix HealthCare of Tennessee, Inc., does not provide uninsured enrollees with an explanation of benefits for copayments and deductibles paid. Industry practice is to provide members with an explanation of benefits when a copayment or deductible is required.

RECOMMENDATION:

Phoenix HealthCare of Tennessee, Inc., should provide uninsured enrollees with an explanation of benefits whenever a copayment or deductible is required from the member.

MANAGEMENT'S COMMENT:

As of January 1, 1996, a deductible is no longer required from our uninsured members. Additionally, our uninsured members are only responsible for *flat* copays for specialists visits, non-preventive dental visits, and pharmacy. In light of these changes, we do not feel it necessary to provide enrollees an explanation of benefits.

DEFICIENCY IN PROVIDER AGREEMENTS

2. FINDING:

Phoenix HealthCare of Tennessee, Inc., did not comply with the TennCare Bureau's requirements regarding provider agreements. The provider agreements did not contain all requirements as specified in section 2-18 of the contract between TennCare and Phoenix HealthCare of Tennessee, Inc.

Section 2-18 of the contract between TennCare and Phoenix HealthCare of Tennessee, Inc., specifies 36 (a through jj) items that provider agreements must include. Among the items missing from provider agreements were:

- w. Provide for payment within thirty (30) calendar days to the provider upon receipt of a clean claim properly submitted by the provider;

- 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 provisions of such records shall be at no expense to TENNCARE;
- 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; and
- ii. Specify that the provider must adhere to the Quality of Care Monitors included in the MCO/TENNCARE Agreement as Attachment IV. The Quality of Care Monitors shall be included as part of the provider agreement between the MCO and the provider.

RECOMMENDATION:

Phoenix HealthCare of Tennessee, Inc., 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:

As of March 13, 1997, Phoenix Healthcare of Tennessee, Inc., has incorporated the following changes to its provider contracts, as related to Section 2-18 of the contract between Phoenix Healthcare of Tennessee Inc., and TennCare:

- w. Language reflecting 30 day payment has been incorporated into provider agreements;
- y. Language reflecting indemnification and hold harmless of TennCare has been incorporated into provider agreements;
- dd. Language to provide records upon termination has been incorporated into provider agreements;
- ff. A conflict of interest clause has been incorporated into provider agreements;
- hh. Specification that provider will be required to accept TennCare reimbursement for TennCare enrollees but not persons covered under another health plan has been incorporated into provider agreements; and
- ii. Language specifying that providers must adhere to the Quality of Care Monitors has been revised to more clearly indicate providers requirement related to the TennCare regulations. Phoenix Healthcare of Tennessee, Inc., however will not include the over 100 page document from the TennCare contract as part of the provider agreement. The language as reflected on Attachment I incorporates these requirements.