

**TENNESSEE MANAGED CARE NETWORK  
D/B/A ACCESS . . . *MEDPLUS***

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

***Arthur A. Hayes, Jr., CPA***

Director

***Ronald M. Paolini, CPA***

Assistant Director

***John R. Mattingly, CPA***

In-Charge Auditor

***Julie Rogers, CPA***

Staff Auditor

***Leslie Bethea***

Editor

February 18, 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) Tennessee Managed Care Network, d/b/a Access . . . *MedPLUS*, 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

cc: Bill Young  
Theresa Clarke

State of Tennessee

# Review Highlights

Comptroller of the Treasury

Division of State Audit

Compliance Review  
**Tennessee Managed Care Network**  
**d/b/a Access . . . MedPlus**  
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 accounting for payments from the TennCare Bureau, proper enrollment counts, maintenance of sufficient financial reserves, and recordkeeping sufficient to meet program requirements.

## REVIEW FINDINGS

### **Denial of Access to Records**

Medical Care Management Company, the management company for Tennessee Managed Care Network (the plan), has denied state auditors access to records regarding material events subsequent to the period under review (page 8).

### **Understatement of Trade Accounts Payable and Errors in Computation of Unpaid Claims Liabilities**

Tennessee Managed Care Network has underreported plan liabilities by \$130,253. Errors were discovered in the calculation of IBNR (incurred but not reported) claims liability. Total unpaid claims liabilities reported by the plan were adequate (page 11).

### **Weaknesses in Management Oversight and Internal Control**

Tennessee Managed Care Network has no internal audit function. Also, a current organizational chart was not provided. In addition, checks from the manual register were not accounted for properly (page 14).

### **Deficiencies in Claims Processing**

Tennessee Managed Care Network has not fulfilled contract reporting requirements regarding encounter data. Also, weekly claims processing reports do not include all information required by the contract. The policy of issuing advance payments continued for the period under review (page 16).

---

"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  
TENNESSEE MANAGED CARE NETWORK  
d/b/a ACCESS . . . MedPLUS  
FOR THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 1995

---

TABLE OF CONTENTS

---

	<u>Page</u>
<u>INTRODUCTION</u>	1
Purpose of the Review	1
Post-Audit Authority	1
Scope of the Review	2
<u>BACKGROUND INFORMATION</u>	2
Prior Review Findings	5
Subsequent Material Events	6
<u>RESULTS OF THE REVIEW</u>	7
Findings and Recommendations	8
1. Denial of access to records	8
2. Understatement of trade accounts payable and errors in the computation of unpaid claims liabilities	11
3. Weaknesses in management oversight and internal controls	14
4. Deficiencies in claims processing	16
<u>Schedule 1</u>	
Summary of Review Adjustments to Statutory Equity	22
<u>Schedule 2</u>	
TMCN TennCare and Non-TennCare Income Statement	23

COMPLIANCE REVIEW  
TENNESSEE MANAGED CARE NETWORK  
d/b/a ACCESS . . . *MedPLUS*  
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 Tennessee Managed Care Network. The purpose of this review was to evaluate the programmatic operations of the managed care organization (MCO) and to determine if Tennessee Managed Care Network 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 enrollment counts and categories are accurate and whether monthly payments and withhold amounts from TennCare to the MCO are accurate;
3. to determine if the MCO has sufficient financial capital to ensure uninterrupted delivery of health care;
4. 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
5. to recommend appropriate actions to correct any deficiencies.

**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 Tennessee Managed Care Network (the plan) for the period January 1 through December 31, 1995. The review included tests of accounting records and other auditing procedures considered necessary. The State of Tennessee has contracted with Peterson Consulting L.L.C. to perform a review of the plan's claims processing system. Their general findings are included in the Findings and Recommendations section of this report (see finding 4). In addition, the State of Tennessee has contracted with Reden & Anders, Ltd., to examine the reasonableness of reported unpaid claims liability. Their actuarial opinion is included in finding 2.

---

## **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 en-roll 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.

Prior to TennCare, Tennessee Managed Care Network, a nonprofit corporation, coordinated medical services for approximately 35,000 Aid to Families with Dependent Children (AFDC) Medicaid recipients in the State of Tennessee. Effective January 1, 1994, the plan contracted with the State of Tennessee as a health maintenance organization (HMO) to provide medical services under the newly established TennCare program. The Tennessee Managed Care Network designated name for the TennCare plan is Access . . . *MedPLUS*. In addition to the Access . . . *MedPLUS* plan, the plan offers two commercial health insurance plans, has investments in two for-profit subsidiaries, and has developmental projects in other states. The officers and directors of Tennessee Managed Care Network are as follows:

Officers:

Anthony J. Cebrun, J.D., M.P.H., CEO/President  
Joseph Barber, C.P.A., Chief Financial Officer  
Babajide Bamigboye, M.D., Secretary

Directors:

Chris R. Arthur, Ph.D.	Albert Head
William Terrell, M.D.	Joshua Gettinger, M.D.
Robert Hardy, M.D.	Russell Ward, M.D.
Sarah Scott	Cassell A. Jordan, M.D.
Richard Carter, M.D.	Anthony J. Cebrun, J.D., M.P.H.
Babajide Bamigboye, M.D.	

At December 31, 1994, the enrollment for the plan was approximately 330,000 members. At December 31, 1995, the enrollment was approximately 281,000. In addition to the basic medical coverage specified in the contract, the plan offered members enrolling in Access . . . *MedPLUS* the following:

- Exemption from copayments and deductibles for uninsured enrollees
- Certain nonprescription items specified in the plan
- Prenatal care incentive packages to include educational materials and pregnancy/ baby-related gifts

A life insurance policy with a \$10,000 death benefit was offered at the inception of the plan in January 1, 1994, but was terminated December 1, 1994.

As an HMO, Tennessee Managed Care Network files quarterly and annual statements with the Department of Commerce and Insurance. The department uses the information from 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 \$6,806,289 to satisfy requirements of the Department of Commerce and Insurance. The annual statement for the year ended December 31, 1995, reported \$66,880,326 in plan assets, \$62,882,572 in liabilities, and \$3,997,754 net worth. Also, total revenues of \$403,806,199 and total expenses of \$385,900,999, resulting in a net income of \$17,905,200 for the period January 1 through December 31, 1995, were reported on the annual statement.

The independent actuary contracted by the plan to express an opinion on the valuation of unpaid claim liabilities is the Osteimer Company, Atlanta, Georgia. Their reported unpaid claims liabilities as of December 31, 1995, was \$59,153,751.

The independent certified public accounting firm contracted by the plan, KPMG Peat Marwick LLP, expressed an unqualified opinion on the financial statements.

## **PRIOR REVIEW FINDINGS**

The previous review of Tennessee Managed Care Network for the year ended December 31, 1994, included the following findings:

### **1. Understatement of Plan Liabilities**

Tennessee Managed Care Network (the plan) inappropriately reduced its liabilities for incurred but not reported medical claims by \$1,000,000 because of overpayments caused by an error in discounting outpatient hospital claims. In addition, the plan did not increase its liability for life insurance proceeds payable by \$150,000 for 15 life insurance claims filed subsequent to year-end claims which had not been recognized. Plan liabilities should be increased by \$1,150,000.

### **2. Overstatement of Plan Assets**

The plan accounted for advanced payments made to providers for services in 1994 as a plan asset. However, because collection of \$1,831,071 for advanced payments is doubtful, plan assets should be decreased by that amount.

### **3. Weaknesses in Claims Processing**

The plan did not have an effective, functioning, claims processing system in place from January 1 through May 1994. The backlog of unprocessed medical claims created the need for advanced payments to providers. The plan established a "hooked" file in which claims were filed by medical providers during 1994, but no action was taken concerning their adjudication until March 1995.

### **4. Weaknesses in Management Oversight and Internal Controls**

Bank reconciliations were not performed for 1994 until March 1995, and key organization positions were not filled until the later part of 1994. The internal audit position at Tennessee Managed Care Network remains unfilled. In addition, Board of Directors minutes indicate there were no board meetings from December 29, 1993, through June 10, 1994.

The total effect of review adjustments was to reduce statutory equity as of December 31, 1994, from a reported \$2,870,552 to \$1,160,104. The plan was below minimum equity requirements as of December 31, 1994. The adjusted statutory equity as of December 31, 1994, reflected review testwork as of May 1995. On October 21, 1995, the independent certified public accountant issued a qualified opinion for the same period. The opinion was qualified because of the uncertainty of a receivable due from the State of Tennessee. The plan later reversed this receivable which adjusted equity/unrestricted net assets to negative \$9,261,277. The reason for the difference between the Division of State Audit's report and the certified public accountant's report is the understatement of the estimate for unpaid claims liability. The independent actuary

contracted by the plan expressed an opinion on the reasonableness of the \$59,599,556 estimate, but by October 1995 this amount had been restated as \$77,342,661. The plan eventually did receive amounts greater than expected for adverse selection (which was the uncertain receivable previously mentioned) as well as retroactive capitation receivables to offset some of the increased liability for unpaid claims.

All previous findings with the exception of finding 2 will be repeated in the current report.

## **SUBSEQUENT MATERIAL EVENTS**

To obtain additional capital, the Board of Directors of Tennessee Managed Care Network sold for \$5.1 million investments in subsidiaries and all fixed assets to Medical Care Management Company, a for-profit corporation, effective March 1, 1996. The President and CEO of the plan, Mr. Anthony Cebrun, is now the President and Chairperson of the Board of Directors of Medical Care Management Company, but he still retains a seat on the plan's Board of Directors. The management agreement grants Medical Care Management Company the authority to supervise and manage the day-to-day operations of the plan. Medical Care Management Company is to be paid a management fee based on a declining scale from 12% to 8% of annual premium revenue plus a performance incentive of 50% of the plan's net profit. Because all former employees of Tennessee Managed Care Network, as well as the President/CEO and other officers, are now the employees of Medical Care Management Company, and because the President/CEO retains a seat on the plan's Board of Directors, the sale transaction and subsequent relationship with Medical Care Management Company are considered related party transactions. As of June 30, 1996, the quarterly wage reports remain filed under Tennessee Managed Care Network. The term of the management agreement is ten years. The Comptroller's Office and the Department of Commerce and Insurance have requested detailed financial information, an organization chart, and the board minutes of Medical Care Management Company, but the information has not been provided (see finding 1). The denial of access to these records creates a scope limitation for this review because of the material effect the administrative actions and financial transactions of Medical Care Management Company have on the continued operations of the plan.

---

## RESULTS OF THE REVIEW

---

Our review of the accuracy of accounting and financial data reported by the plan, along with Peterson Consulting L.L.P.'s review of the claims processing system, revealed discrepancies which are further discussed in the Findings and Recommendations section of the report. A summary of review adjustments to statutory equity is presented in schedule 1. A restated income statement as a result of review adjustments for the year ended December 31, 1995, is presented in schedule 2.

Subsequent cash payments greater than reported receivable amounts will increase reported equity by \$1,137,461 for the year ended December 31, 1995. This adjustment consists of an increase of \$637,515 to adverse selection receivable, \$499,946 to the pharmacy receivable, and \$50,565 to the retroactive capitation receivable. The effect of the subsequent payments is reflected in the Summary of Review Adjustments to Statutory Equity (see schedule 1).

## FINDINGS AND RECOMMENDATIONS

### DENIAL OF ACCESS TO RECORDS

1. FINDING:

Medical Care Management Company, the management company for Tennessee Managed Care Network (the plan), has denied state auditors access to records of material events subsequent to the period under review. The records denied include a detailed general ledger and trial balance, an organization chart for Medical Care Management Company, and minutes of the Board of Directors meeting for Medical Care Management Company.

Section 2-13 of the contract between the plan and the state specifies that “the CONTRACTOR shall make all records available at the CONTRACTOR’s expense for review, audit, or evaluation by authorized federal, state, and Comptroller of the Treasury personnel.” Also, Section 2-16 of the contract specifies that “the CONTRACTOR shall make available to TennCare or its representatives and other authorized state and federal personnel . . . all records, books, documents, and other evidence pertaining to this Agreement, as well as appropriate administrative and/or management personnel who administer the plan.”

The substance of the relationship between the plan and Medical Care Management Company indicates that the organizations are under common control and therefore are related parties. Consequently, both are considered the contractor. Even if the entities were not under common control and if Medical Care Management Company was considered an independent contractor to the plan, the TennCare contract also provides for auditor access to the records of each entity. Section 1-4 of the TennCare contract provides that all terms of the contract, which would encompass Sections 2-14 and 2-16 referred to above, “apply to providers, volunteers, and any one else acting on or behalf of the CONTRACTOR.” By refusing to provide the information requested, the plan and Medical Care Management Company are in violation of the TennCare agreement.

Our inability to review all supporting documentation for incurred expenses limits our ability to provide useful information on the operation of the TennCare Program to the TennCare Bureau and the Health Care Financing Administration. It is important that the state be aware of the nature of, as well as the amount of, the various costs being incurred by the TennCare managed care contractors as it continues to evaluate and improve the program.

RECOMMENDATION:

Tennessee Managed Care Network and Medical Care Management Company should provide the requested information to state auditors. If access to the information is denied in future examinations, that action should be deemed a breach of contract, and the state should pursue the appropriate remedies as specified in the contract.

MANAGEMENT'S COMMENT:

Medical Care Management Company (MCMC) allowed the auditors access to all of the records regarding any event, material or otherwise, during the audit period or subsequent to the audit period. Unfortunately, this report is replete with factual inaccuracies and misrepresentations. Additionally, it mischaracterizes transactions and occurrences, presenting them in such a way as to suggest an inference of improper and unwarranted actions by MCMC officials. MCMC takes exception to these attempted inferences, and vehemently objects to the overall negative and demeaning tenor of this report.

Nowhere is this practice more evident than in the first "Finding and Recommendation," which alleges that MCMC officials denied state officials access to its records relevant to TMCN. Throughout the three month period in which state officials were present in MCMC's offices, any and all records were readily available, including TMCN's general ledgers, trial balances, financial statements, and minutes from all Board of Director's meetings relevant to TMCN transactions, which were approved and available at the time of their visit. Until June 1996, all MCMC disbursements were done through TMCN's checking accounts. The information sought relevant to MCMC was contained in TMCN ledgers, which the auditors reviewed extensively. Therefore, although the information sought was perhaps not in the specific format requested, it was readily available. The organizational chart was not available due to the unsettled determinations as to organizational structure. At no time and in no instance were auditors denied access to any records relevant to TMCN when on-site review was requested during their visit. TMCN unequivocally denies the allegations of noncompliance with Section 2-13 of the TENNCARE Contract. In good faith and a spirit of cooperativeness, TMCN honored every reasonable request by the auditors for on-site access to any and all records made during normal business hours within the three month visit.

The most blatant and inexcusable misrepresentation concerns the auditor's characterization of the asset purchase transaction and subsequent relationship between TMCN and MCMC as "related party transaction," a dangerously close to libelous inference that the transaction was not conducted in good faith and resulted in a less than fair market price. Please note that this transaction was the culmination of four years of deliberations by TMCN's Board of Directors on various options available to TMCN towards restructuring the company so as to gain access to capital. Prior to any preliminary determination as to the course of action to be taken, TMCN's Board of Directors retained Stokes and Bartholomew of Nashville as special legal counsel and Morgan Stanley as special financial

consultant to initiate its due diligence. An independent evaluation of the assets purchased in the transaction was prepared by equitable securities. Finally, the transaction was approved by the TennCare Bureau and the Department of Commerce and Insurance. Approval was also requested of the Attorney General, who deferred to the decision of the regulatory services. At no time was Mr. Cebrun involved in either the selection of the consultants or the deliberations of the Board with regard to this matter.

The report contends that “Since all former employees of Tennessee Managed Care Network, as well as the President/CEO and other officers, are now the employees of Medical Care Management Company, and the President/CEO retained a seat on the board of directors of Tennessee Managed Care Network, the asset purchase transaction and subsequent relationship with Medical Care Management Company are considered related party transactions.” This statement is seriously flawed for several reasons. First, while it is true that former employees of TMCN now work for MCMC, that is not an uncommon occurrence in transactions of this type and is generally accepted as standard business practice. More importantly, the determination of what constitutes a “related party transaction” is not the disposition of employees involved in corporate mergers, acquisitions, and asset purchases, but whether the Board of Directors, even with common membership, acted in good faith and fulfilled their fiduciary duty to ensure the transaction resulted in a fair market price. The minutes of TMCN Board of Directors’ meetings (which were made available to the auditors) clearly show that Mr. Cebrun, the only common member of the two boards, recused himself from any dealings regarding the transaction and did not vote on any related matters. Second, an independent assessment, made available to the auditors, clearly indicates that a fair market price was not paid in this transaction. Please note that MCMC paid book value for the non-admitted fixed assets it purchased from TMCN; it is very unusual for a company to pay book value for fixed assets as was done by MCMC. Third, the auditors were aware that the transaction received the approval of Mr. Rusty Siebert, TENNCARE Bureau Chief, and Mr. Douglas Sizemore, Commissioner of the Department of Commerce and Insurance. Similarly, when TMCN requested that the Attorney General review the transaction, that request was declined and the Attorney General deferred to the determination of both the Departments of Commerce and Insurance and Finance and Administration, both of which approved the transaction. To suggest that the transaction was less than “above board” in blatant, knowing disregard to the truth is inexcusable; we strongly urge that this section be deleted from the report.

### **REBUTTAL:**

**During the time we were on-site at MCMC, we asked for a detailed accounting of the business transactions of MCMC. At first, MCMC questioned our authority for access to those records claiming MCMC was a separate company from Tennessee Managed Care Network (TMCN). Subsequently, we did receive a summary general ledger for MCMC for March 1996. At no time did MCMC advise us that supporting details for the summary ledger were available in the TMCN general ledger information. In the copy of the TMCN revenue and expense state-**

ment provided to us, the only transaction recorded for March 1996 administrative costs is the management fee paid to MCMC. This would indicate that details of the MCMC administrative expenses would have been on their separate ledger.

We did receive Board of Directors' minutes for TMCN but not for MCMC.

We maintain that the transaction between TMCN and MCMC is a related-party transaction since Mr. Cebrun maintains a position on the boards of both entities. We did not state nor mean to imply that by referring to the transaction as "related-party" that it was not conducted in good faith or not "above board." Related-party transactions are common occurrences in everyday business.

---

UNDERSTATEMENT OF TRADE ACCOUNTS PAYABLE AND ERRORS IN  
THE COMPUTATION OF UNPAID CLAIMS LIABILITIES

2. FINDING:

Tennessee Managed Care Network underreported plan liabilities by \$130,253 on the annual statement for the year ended December 31, 1995. Also, errors were discovered in the computation of components of medical claims payable processed by the claims processing system. The following discrepancies were noted:

- The liability the plan's independent actuary established for medical payments for home health, durable medical equipment, infusion, and hospice service for enrollees was understated by \$2,316,374 for the year ended December 31, 1995. The claims for these services were processed by a single vendor. The settlement reached with this vendor in June 1996 exceeded the liability established for 1995. Also, the plan has not provided an allocation of this settlement based on dates of service.
- The liability the plan's the independent actuary established for claims processed by the plan's computer system contains a keying error (by the actuary) of \$1,000,000 for claims paid during 1994, and the payments reports prepared by the claims processing system double-counted a check run for \$2,641,653. An accurate total of claims paid is significant because it is used by the actuary in the calculation of IBNR (incurred but not reported) claims liability. Also, the plan's reconciliation of claims payment lag reports with the general ledger is inaccurate because of the double-counted check run.
- Trade accounts payable is underreported by \$116,491 as of December 31, 1995.

- The net increase of the revenue receivables for adverse selection and retroactive capitation will increase in premium tax payable and premium tax expense by \$13,762.

The independent actuary contracted by the State of Tennessee has applied the settlement with the vendor for home health, durable medical equipment, infusion, and hospice services, and the correct amount of claims payments in the recomputation of unpaid claims liabilities. The analysis performed by Reden & Anders, Ltd., indicated that the unpaid claim reserves held at December 31, 1995, were adequate. Total unpaid claims liabilities reported by the plan is a conservative estimate, but components of this liability remain erroneously computed. Adjustments for trade accounts payable and premium tax payable are not related to unpaid claims liabilities and will be adjusted from equity by the Division of State Audit.

#### RECOMMENDATION:

Tennessee Managed Care Network should increase the reported liabilities by \$130,253 for the year ended December 31, 1995. The errors noted in the computation of medical claims liability should be corrected. Tennessee Managed Care Network should reconcile claims payments lag reports with the general ledger each quarter. Trade accounts payable should be reported for the amounts actually due. The effect of the understatement of plan liabilities is reflected in the Summary of Review Adjustments to Statutory Equity (see schedule 1).

#### MANAGEMENT'S COMMENT:

TMCN was involved in claims settlement negotiations with our home health vendor. The final settlement, paid in June 1996, included all claims for FY 1995 through May 22, 1996, and amounted to \$4,700,000. On December 31, 1995, TMCN had reserves in excess of the total amount suggested by its independent actuary. The excess reserves on December 31, 1995, and those recorded for home health in 1996, are more than adequate to cover the net difference and the review performed by Reden & Anders, Ltd. (actuaries hired by the Department of Commerce and Insurance) substantiates the adequacy of our reserves.

The \$1,000,000 keying error was in 1994, not 1995, and has no relevance to this audit period and should be removed. Two claims payment cycles were processed for the remittance advice dated 9/8/95. The first cycle was interrupted before completion, and rerun. Only the second processing cycle for claim payments of \$2,641,653 was recorded as medical payments in the general ledger. The reconciliation between the general ledger medical payments and the lag report is not inaccurate.

In an effort to include all 1995 incurred administrative cost, TMCN recorded all subsequent payments relating to 1995 for the first three weeks of January 1996 as liabilities for administrative expenses in the December 31, 1995, year-end financial statements. This cut-off period was established by management in order to facilitate the year-end closing process. The unrecorded trade accounts payable of \$116,491, only 0.6% of TMCN's net income, were all paid between January 25, 1996, through February 25, 1996, and were originally noted by our external auditors KPMG during their audit. Given the immateriality of the amount involved, no adjustment was proposed by our external auditors. The \$116,491 was recorded in 1996. In the future, we will consider extending our cut-off for accounts payable through the end of January.

We agree with the revised premium tax liability because the net effect of the following adjustments results in an increase to our premium tax payable.

The auditors are correct - the liabilities reported by TMCN were conservative. However, the components of the liabilities were not erroneous but were related to the information available to us at the time we filed our 1995 Annual report. Again, Reden and Anders, Ltd., actuaries hired by TDCI, confirmed the adequacy of TMCN's claims reserves.

The financial portion of the audit was based on the December 31, 1995, Annual Statement to the Tennessee Department of Commerce and Insurance (TDCI). This report was submitted to TDCI on February 23, 1996. Audits usually allow hindsight to assist the auditor in reviewing financial information which is not available to the organization when making its best estimates at the time of closing a financial statement period. However, based on reviews of activity for the period after the fact, additional trade payable liabilities of \$130,253 should be recorded. The auditors recommend adjustments to increase liabilities to \$130,253 and increase assets by \$1,188,026 for the year ended December 31, 1995, and other adjustments as reflected in Schedule 1. TMCN agrees with the revision to increase statutory equity from \$3,997,754 to \$5,055,527 at December 31, 1995.

### **REBUTTAL:**

**While it is true that reserves in total were adequate, that is not a good reason to minimize the need to accurately determine reserve components.**

**The \$1,000,000 keying error was included in the base statistic used to compute medical services for 1995 and would have some effect on its accuracy. Although the \$2,641,653 may have only been recorded in the general ledger once, it was nonetheless included twice in the paid lag reports used by the actuary to compute medical claims payable. Since this amount was used in the reconciliation of the paid lag reports with the general ledger, the reconciliation could not have been accurate.**

---

WEAKNESSES IN MANAGEMENT OVERSIGHT  
AND INTERNAL CONTROLS

3. FINDING:

For the period under review, several management weaknesses were noted in our examination:

- Tennessee Managed Care Network has no internal audit function. Although the plan did contract in 1995 with an external organization to serve in this function as well as with other consultants to perform studies and analysis of the claims processing system, management has state that “there are no internal audits of the claims processing system” performed by the external organization. In addition, the consultants’ reports are not available. However, interviews with claims processing personnel confirmed that testing was performed on the system. An internal audit staff is a basic component of an internal control system, and internal auditors should be evaluating the efficiency of claims processing and financial operations and reporting to management to ensure independence.
- The plan could not provide a current organizational chart of the operations of the company. Management has stated that an organization chart has not been finalized because of various issues pertaining to staffing and systems which are yet to be determined.
- Review of the manual check register revealed that 56 checks could not be accounted for as either void, paid, or ruined.

RECOMMENDATION:

Tennessee Managed Care Network should staff or contract the function of internal audit. The internal audit staff should be able to evaluate the efficiency of claims processing and financial operations. Organizational charts should be updated to reflect the responsibilities and authorities of management and staff. The sequence of all manual checks should be accounted for properly.

MANAGEMENT’S COMMENT:

While TMCN is not required to have an internal audit function by the terms of the Contractor Risk Agreement, the state made the request and we conceded. The Expedious Service (ESI) is the internal audit firm contracted by TMCN to provide these serv-

ices. The ESI staff members assigned to TMCN are highly experienced. TMCN has complete confidence in their ability to perform the internal audit function. Again, the auditors are dangerously close to libel in suggesting that there is no internal audit function when the auditor is very aware (based on the TDCI examination for the period ended August 31, 1995) that ESI performs internal audit for TMCN.

If the auditor's interviews with TMCN "claims processing personnel confirm that testing was performed on the claims processing system," then this is true. However, by the auditor's own analysis (Peterson Consulting, LLC) the claims processing function of TMCN has greatly improved, with minor problems. It is also the duty of internal audit to inform management of its assessment of risk regarding a particular issue and immediately provide management the opportunity to make the necessary changes.

The organizational chart was not available due to the unsettled determinations as to the organizational structure.

Checks #038990-039044 (55 checks) were originally processed on check-run dated March 2, 1995, for transportation payments. These checks were listed as "outstanding" on the check register given to the examiners during their audit. The entire March 2, 1995, check-run was subsequently voided due to the system generated check numbers not matching the check numbers pre-printed on the physical checks. In our efforts to locate these checks, we were searching for the system generated check numbers instead of the pre-printed check numbers on the actual check. After further clarification from the auditors, we began searching for the actual check numbers, and these checks were then located in the journal entry binders as back-up documentation for the voided transactions. These checks were offered at the January 3, 1997, examination exit conference for review. Check number 41426 was the only voided check which could not be located for review by the examiners. As explained to the auditors while performing field work and explained again above, all check numbers have been accounted for.

### **REBUTTAL:**

**There was no documentation of the work performed by Expeditious Service.**

**MCMC should have been able to provide documentation for the 56 manual checks from a March 1995 check run during field work in July 1996. Instead, the checks were presented for review in January 1997 when the audit was concluding.**

## DEFICIENCIES IN CLAIMS PROCESSING

### 4. FINDING:

Tennessee Managed Care Network has not fulfilled contract reporting requirements. The following problems were noted:

- The plan did not comply with the TennCare Bureau's requirements regarding encounter data for 1995. Encounter data, a record of the medical services provided to enrollees, is necessary for evaluation of quality of care and access to TennCare services. Settlements, manual payments, and special pricing arrangements are not reported to TennCare for encounter data purposes because the plan's claims processing system is unable to capture the encounter data related to these claim payments. Section 2-11.f. of the contract between TennCare and Tennessee Managed Care Network requires that encounter data be reported in a specified format.
- An additional \$368,680 in provider advances has been determined uncollectible by the independent outside accountant. The plan has continued to issue provider advances during calendar years 1995 and 1996. The plan began the policy of issuing provider advances in 1994 because the claims processing system was unable to adjudicate claims in a timely manner. As the system was able to process claims, the advance payments balance began to decrease. An allowance has been established to reduce the advance payments balance for uncollectible payments. The allowance for uncollectible provider balances should be adjusted to \$2,899,536 for the year ended December 31, 1995, for the additional provider balances determined uncollectible. The plan correctly reduced plan assets for the remaining provider balances for December 31, 1995.
- Weekly claims processing reports are not in compliance with contract requirements. Section 2-11.g. of the TennCare contract requires the plan to report to TennCare certain information on a weekly basis. The following items were not included in these weekly reports: (1) average time from receipt to final payment of claim by service type; and (2) approximate waiting time for member response.

Additionally, the State of Tennessee has retained an independent consulting firm, Peterson Consulting L.L.P., to assist in the examination of the claims processing system and the determination of the claims payable amount. Peterson Consulting's summary of the major issues identified is as follows:

- In the course of Peterson Consulting's initial field work, various TMCN personnel represented that several internal audits/studies had been prepared by both TMCN and Expeditious Services, Inc. (ESI), an external firm engaged to

perform internal audit functions. It was represented that these internal audits/studies related to reviews of both TMCN's mainframe claims processing system and the claims processing system used to adjudicate transportation claims. However, contrary to these representations, in correspondence dated June 25, 1996, TMCN indicated that "...no internal audits of the claims processing system [were] performed by ESI." Additionally, the correspondence stated that "[t]here is no report prepared by [TMCN] available at this time; system testing is on-going" and "[t]here are no internal audits of transportation claims available performed by ESI." The fact that no internal audits/studies have ever been performed on TMCN's respective claims processing systems adversely affected Peterson Consulting's risk assessment of TMCN's claims processing environment.

- In order to verify the completeness of the population of claims and to provide a level of assurance to the actuary that all claims payments were captured for testing, Peterson Consulting requested a detailed reconciliation of TMCN's LAG reports, check registers, and its general ledger for the periods ended December 31, 1995, and March 31, 1996. TMCN's Accounting Department could not provide Peterson Consulting with the requested reconciliation, as TMCN has never performed such a reconciliation. Therefore, Peterson Consulting performed this analysis with the assistance of various TMCN accounting personnel and was able to account for material differences between system generated LAG reports, check registers and the amounts recorded in the general ledger.
- Peterson Consulting's testing included the pricing of claims to determine whether claims are being paid in accordance with contractual terms agreed upon between TMCN and providers. This testing generally consists of tracing paid amounts to the appropriate provider contracts and/or fee schedules to verify the pricing accuracy. Peterson Consulting requested copies of provider contracts and/or fee schedules for a subsample of finalized claims on numerous occasions from TMCN. To date, Peterson Consulting has not received all of the documentation necessary to complete the price testing, as TMCN has represented that certain requested provider contracts are unavailable.

The lack of provider contracts alerted Peterson Consulting of a potential control weakness related to TMCN's document retention policies. Additionally, because all requested provider contracts were not available for review, Peterson Consulting was unable to determine whether all claims were adjudicated accurately.

- During its review, Peterson Consulting learned that mental health and substance abuse claims are processed and paid by ProPsych, Inc. (ProPsych). ProPsych is TMCN's only claims processing subcontractor which reimburses claims on a fee-for-service basis. Based on conversations with TMCN per-

sonnel and our review, Peterson Consulting determined that TMCN has never reviewed or audited the claims processing operations of ProPsych. Additionally, it was represented to Peterson Consulting that TMCN has never reconciled paid claims data to the dollar volume of claims invoiced to TMCN. Consequently, Peterson Consulting performed detailed testing of the claims processing policies and procedures employed by ProPsych in the adjudication of mental health and substance abuse claims.

- Throughout testing of the claims processing systems of both TMCN and ProPsych, Peterson Consulting discovered several claims adjudication errors resulting from human intervention. Additionally, manually adjudicated claims generally required greater processing times than those claims which were electronically adjudicated. TMCN is currently in the process of transitioning the majority of its manual claims processing functions to its automated main-frame claims processing system. This transition should result in a decrease in both processing time and adjudication errors.
- The average number of days to finalize claims during the entire testing period of January 1, 1995, through March 31, 1996, was approximately 43.96 days; the average of days to finalize claims during the final quarter of testing (i.e., the first quarter of 1996) was approximately 32.26 days. Based on these averages, it appears that TMCN is adjudicating claims more efficiently than in previous periods.
- Based upon TMCN's interpretation of the definition of a "clean claim," TMCN appears to be meeting its contractual obligations with respect to the timely adjudication of claims. However, due to the different interpretations of the clean claim definition by TMCN and BCBST, which was also reviewed by Peterson Consulting, the results of the timeliness testing between the two MCOs are not comparable. TMCN has adopted the interpretation that any pended claim is considered an unclean claim, whereas Blue Cross Blue Shield of Tennessee has adopted an interpretation which considers a claim to be unclean only if additional information must be acquired from sources outside of the organization. If TMCN had adopted the same interpretation of the clean claim definition as BCBST, the percentage of clean claims adjudicated in a timely manner would have been lower.

#### RECOMMENDATION:

Tennessee Managed Care Network should submit all encounter data in the format specified by the Bureau of TennCare. The claim processing system should be updated to capture all types of claims payments. Tennessee Managed Care Network should adhere to contract guidelines regarding the submission of weekly claims processing reports.

Tennessee Managed Care Network should continue to improve the claims processing system.

MANAGEMENT'S COMMENT:

TMCN is reporting its encounter data to TennCare via weekly claims processing reports. The format for encounter data to be sent to TennCare is a claim format. In many cases, settlements, manual payments, and special pricing arrangements are not payments for specific claims. In these cases, there is no data available to the mainframe system for the production of encounter data. When settlements or special payments are made for specific claims, they are processed to pay "zero dollars" and the encounter data is created for TennCare. Encounter data is created for all claims processed through the mainframe claim processing system.

At December 31, 1995, the advances to providers were not included as an admitted asset in the Annual Report, and therefore, we don't understand why this is even addressed as a finding. The audited financial statements for 1995 of TMCN included an increase in the allowance for uncollectible payments of \$368,680. This prior period adjustment to the Annual Statement was included in the March 31, 1996, Quarterly Report to TDCI. The auditors admit TMCN correctly reduced plan assets for the remaining provider balances for December 31, 1995.

This report is being sent to TennCare on a weekly basis. TMCN is complying with the contract guidelines. In order to better assist the TennCare Bureau, our form is being revised to change the headings of the section where the requested information is located. However, the format TMCN is using to report to TennCare weekly was approved by TennCare.

*The following comments relate to the report of Peterson Consulting L.L.P.:*

TMCN does not understand this statement being in the Comptrollers audit report. There seems to be a misquote or misinterpretation by Peterson Consulting of what was said or meant. Reviews completed by ESI or TMCN did not necessarily result in a report. The changes needed were addressed with the proper personnel in the claims processing function and were made. It is not a requisite of our contract for TMCN to have an internal audit staff or firm, though ESI provides that service. Additionally, it is unclear to TMCN how an external firm hired by TDCI to "... assist in the examination of the claims processing system and the determination of the claims payable amount..." were "adversely affected" in their "risk assessment of the claims processing environment." It seems to us that even if "audit/studies" were available, the same amount of work would have still been required by Peterson Consulting to complete their assignment.

For 1995, a top-level reconciliation between the lag report and the general ledger was performed by TMCN. Currently, a quarterly reconciliation between the lag report and the general ledger is being performed. All check register payment information is

systematically downloaded through the accounting system to the general ledger. During the process of reconciling the lag report to the general ledger, the check register payment information is verified. Payments and credits not processed through the lag report, but appearing in the general ledger, are reconciling items. These reconciling items could be manual payments, wire transfers, voided checks, and/or refunds.

TMCN is in the process of re-contracting with all of our providers due to requirements by TennCare that certain language be included in our provider contracts for compliance purposes. The new contracts are complete and approved by the TennCare Bureau and will be used in all future contracting.

Currently, all mental health and substance abuse claims which are not covered by BHOs (Behavioral Health Organizations) are still being reviewed by ProPsych.

TMCN is currently in the process of transitioning the majority of its manual claims processing functions to its automated mainframe claims processing system.

TMCN concurs with Peterson's calculation of average number of days to finalize claims.

TMCN's definition of a "clean claim" comes from the Contractor Risk Agreement and is applied accordingly. Given that this is an audit of TMCN's contractual compliance with regard to the timely adjudication of claims, the only objective should be to ensure that TMCN meets its contractual obligation to expeditiously process its "clean claims." As such, it is wholly inappropriate to compare TMCN's methods and processes to those of any other managed care organization. The comparison with Blue Cross/Blue Shield's methods is particularly unwarranted and ill-placed, given that it is a comparison between a non-risk bearing PPO and a risk-bearing HMO. The state acknowledges that TMCN is meeting its contractual obligation, which is all that we are required to do; therefore, no further comments or findings are warranted.

### **REBUTTAL:**

**To the extent possible, TMCN should reflect price adjustments in encounter data submitted to the state.**

**The purpose of the reference to advanced payments was not to reflect their status as an admitted asset nor to show the impact of the advances on the financial statements. The purpose was simply to show that advance payments are still being made at a time when the claims processing system should be functioning in a manner which would preclude the need for advance payments.**

**If the revised format includes the two elements previously missing, then it would satisfy this reporting requirement.**

**The remainder of management’s comments refer to the findings of Peterson Consulting L.L.P. which we included in summary form in finding 4 of this report. The entire report of Peterson Consulting is available from the Comptroller’s Office on request.**



