

**Blue Cross and Blue Shield of Tennessee
TennCare Operations**

**For the Period
January 1 through December 31, 1995**

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March 16, 1998

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 financial and compliance review of the managed care organization (MCO) Blue Cross and Blue Shield of Tennessee 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
97/014

cc: Bill Young
Theresa Clarke

State of Tennessee

Review Highlights

Comptroller of the Treasury

Division of State Audit

Compliance Review

Blue Cross and Blue Shield of Tennessee

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

Deficiencies in Claims Processing System

Blue Cross and Blue Shield of Tennessee needs stronger controls over record retention. Payments to medical providers are not always based on the negotiated rate (page 6).

Deficiencies in Provider Agreements

Blue Cross and Blue Shield of Tennessee did not include in its provider agreements all requirements specified by the TennCare contract (page 9).

“Review Highlights” is a summary of the report. To obtain the complete review report which contains all findings, recommendations, and management comments, please contact

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**Compliance Review
Blue Cross and Blue Shield of Tennessee
For the Period January 1 through December 31, 1995**

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**Compliance Review
Blue Cross and Blue Shield of Tennessee
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For the Period January 1 through December 31, 1995**

INTRODUCTION

OBJECTIVES OF THE REVIEW

This report details the results of a compliance review of the transactions, books, and accounts of Blue Cross and Blue Shield of Tennessee. The purpose of this review was to evaluate the programmatic operations of the managed care organization (MCO) and to determine if the Blue Cross and Blue Shield of Tennessee plan 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;
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-REVIEW 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

We examined the records, transactions, and contract provisions of Blue Cross and Blue Shield of Tennessee for the period January 1 through December 31, 1995. The review included tests of insurance claims, review of accounting records, and other review 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 of this report (see finding 1). In addition, the State of Tennessee has contracted with Bob Gold & Associates, Inc., to examine the reasonableness of reported unpaid claims liability. The actuarial opinion is included in the Results of the Review section.

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 contracted with 12 managed care organizations that manage and provide care for enrolled recipients 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 prior to the commencement of the TennCare program 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. ensure 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 offered in Tennessee no later than 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.

Blue Cross and Blue Shield of Tennessee is a not-for-profit corporation headquartered in Chattanooga, Tennessee. Effective January 1, 1994, the plan 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, Blue Cross and Blue Shield of Tennessee had approximately 543,000 members. At December 31, 1995, their enrollment was approximately 598,000. The Executive Committee of the Board of Directors for Blue Cross and Blue Shield of Tennessee is as follows:

James L. Johnson, Chair
Herbert H. Hillard, Vice Chair
J. D. Elliot, Secretary/Treasurer
Nelson C. Andrews
John F. Germ
Jim Whitlock

As a PPO, Blue Cross and Blue Shield of Tennessee must establish risk reserves in an amount equal to what would have been required by the Tennessee Department of Commerce and Insurance if the plan had been a health maintenance organization licensed by the State of Tennessee. Also, the plan is allowed to retain up to ten 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 Blue Cross and Blue Shield of Tennessee. In the event of savings, the plan, 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 five percent of the savings with the providers. The contractor shall be allowed to retain five percent for the contractor's efficiency. The remainder of the savings shall be returned to TennCare.

Blue Cross and Blue Shield of Tennessee 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. Statutory accounting differs from generally accepted accounting principles because assets must be easily converted to cash to pay for outstanding claims. Assets such as furniture, equipment, and prepaid expenses are not to be included in the determination of plan assets and should be reduced from equity. As of December 31, 1995, the amended annual statement for all operations of Blue Cross and Blue Shield of Tennessee reported \$846,841,311 in plan assets, \$549,041,273 in liabilities, and \$297,800,038 in total reserves and unassigned funds. Total reserves and unassigned funds comprised \$214,296,541 in statutory reserves and \$83,503,497 in unassigned funds. A separate statement of revenue, expenses, and net worth for the TennCare operations of Blue Cross and Blue Shield of Tennessee reported total revenues of \$827,189,437 and total expenses of \$832,591,151, producing a net loss of \$5,401,714 for the period January 1 through December 31, 1995. Revenue comprised \$822,376,507 in capitation fee payments from TennCare and \$4,812,930 in interest income. The plan reported \$765,821,875 in medical and hospital expenses and \$66,769,276 in administrative expenses.

PRIOR REVIEW FINDING

The previous review of Blue Cross and Blue Shield of Tennessee for the year ended December 31, 1994, included the following finding:

Incorrect Application of Deductibles and Copayments

Blue Cross and Blue Shield of Tennessee incorrectly calculated deductibles and copayments for certain inpatient hospital claims. Because of the error, Blue Cross and Blue Shield of Tennessee is paying an additional \$543,968.99 to hospital providers.

Blue Cross and Blue Shield of Tennessee developed procedures to correctly calculate deductibles and copayments. The finding will not be repeated in the current report.

RESULTS OF THE REVIEW

Our review of the plan's claims processing system is further discussed in the Findings and Recommendations section of the report. Our review of the plan's accounting and financial data revealed no material discrepancies.

The analysis of the claims liability for TennCare operations by Bob Gold & Associates, Inc., indicated that the liability established by Blue Cross and Blue Shield of Tennessee was sufficient to provide for future claims and settlement of liabilities for December 31, 1995.

Based on specifications of the TennCare contract, we have computed a plan loss of \$16,214,799 for the year ended December 31, 1995. Schedule 1 exhibits the settlement calculation according to the Division of State Audit.

Cash payments until December 31, 1996, for the calendar year 1995 services were used in the savings calculation. Some payments may still be outstanding for calendar year 1995 services. The plan provided IBNR (incurred but not reported) estimated medical payable amounts that had been based on an actuarial study.

Subsequent material events affected the annual statement reporting for TennCare operations of Blue Cross and Blue Shield of Tennessee for the year ended December 31, 1995. The plan included in TennCare revenues an \$8,700,000 receivable for retroactive eligibility, a \$7,049,042 receivable for adverse selection payments, and a \$6,725,000 receivable for pharmacy rebates. Actual payments for the eligibility receivable, adverse selection, and pharmacy rebates were \$2,971,570, \$5,875,540, and \$8,391,072, respectively. After considering the medical payments and return of withholds as of December 31, 1996, for medical services for contract year 1995, medical expenses are overstated by \$10,374,775. Accounting for subsequent payments and the application of premium tax will not materially effect the statutory reserves of Blue Cross and Blue Shield of Tennessee.

FINDINGS AND RECOMMENDATIONS

1. Deficiencies in the claims processing system

Finding

Deficiencies were discovered in the claims processing system of Blue Cross and Blue Shield of Tennessee (BCBST). A non-statistical sample of 55 adjudicated claims for dates of service January 1 through December 31, 1995, revealed the following:

- The claim documents for four adjudicated claims could not be found;
- One hospital provider was underpaid \$3,304.83;
- The primary diagnosis was incorrectly recorded from one claim; and
- Four claims were incorrectly denied but later were reprocessed and paid correctly.

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

- BCBST has a well defined system of internal controls related to the adjudication of TennCare claims. Generally, for those areas where potential weaknesses exist, BCBST has developed compensatory controls. For example, the internal controls related to ensuring that claims are processed include routine audits of Claims Associates' desks, trash cans and general work areas. In addition, BCBST's Quality Assurance Department, Team Leaders and Staff Assistants perform routine periodic reviews of processed claims to ensure the accuracy of the work being performed by the Claims Associates.
- BCBST should evaluate its internal policies and procedures with respect to the control of incoming TennCare paper claims. BCBST's current system does not control incoming TennCare claims in the mailroom, thereby creating the potential for claims to be lost prior to adjudication.
- BCBST should develop a control system which ensures that claims receive the appropriate julian date. This will improve the accuracy of BCBST's claims adjudication timeliness calculations. Peterson Consulting's review indicates that julian dates related to claims which are re-routed from TennCare Support or Data Collection Services to the ID and Routing Department are likely to receive claim submission numbers which include incorrect julian dates.

- Finalized claims appear to have been adjudicated in an accurate and timely manner in accordance with BCBST's contractual agreement with TennCare.
- Based on Peterson Consulting's testing of finalized claims, a potential weakness was identified in the claims adjudication area. It appears that select Claims Associates have the ability to override processing edits so that claims which should be denied are paid. However, this situation does not currently appear to be a significant claims adjudication risk, as testing results indicated that it occurred in less than one-half of one percent of the claims tested.
- Based on Peterson Consulting's testing regarding the calculations of pricing, withhold, deductible and coinsurance amounts, it appears that BCBST's claims adjudication system accurately calculates each of these amounts. Additionally, each remittance advice appears to tie directly to the appropriate finalized claim.
- Peterson Consulting identified a potential control weakness regarding the accumulation of deductible and coinsurance amounts on the TEAMS processing system. Based on conversations with BCBST management, however, the implementation of the AMISYS processing system will eliminate this weakness. [TEAMS and AMISYS are the names of claims processing systems. BCBST began using AMISYS on November 1, 1995, to replace TEAMS.]
- Peterson Consulting's findings related to the processing of mental health and substance abuse claims indicate that between April 1995 and October 1995, BCBST experienced significant difficulties in meeting its contractual timeframes for processing these claims. After further review, it was determined that these processing delays occurred during a time period in which BCBST was transitioning this processing to a subcontractor. Subsequent to this transitional period, it appears that the mental health and substance abuse claims processed by BCBST were processed accurately and within the mandated timeframes.
- BCBST should review its internal policies and procedures with respect to the management of suspended claims maintained on the TEAMS system, as no management system currently exists. It should be noted, however, that BCBST has already developed strong internal policies and procedures with respect to the management of suspended claims maintained on the AMISYS system. The AMISYS processing system is tentatively scheduled to completely replace the TEAMS processing system by late 1996.
- Claims are being inappropriately paid or denied as a result of inconsistencies between the eligibility data maintained by the State and that maintained by BCBST. According to BCBST management, BCBST is currently working in conjunction with the State to attempt to reconcile the differences in the TennCare eligible population.

Recommendation for State Audit Finding

Blue Cross And Blue Shield of Tennessee should develop stronger controls over the record retention of claims submitted by providers. The underpayment to the hospital provider noted in the State Audit sample should be corrected. Blue Cross and Blue Shield of Tennessee should continue to improve the claims processing system.

Management's Comment on State Audit Finding

BCBST concurs with the need for internal quality and control regarding the flow of incoming claims. This deficiency was also cited in the 1996 Department of Commerce and Insurance examination of BCBST's TennCareSM operations. Since the initial report was provided, BCBST's Compliance and Regulatory Assurance Department has performed routine audits of claims; tracking them from point of entry through adjudicating and filing. This process has resulted in improved coordination between the corporate mail room and the TennCareSM operation.

BCBST's corporate Internal Audit and Quality Assurance Department randomly audits the TennCareSM operation on an ongoing basis. During 1996 and 1997, the TennCareSM division also created a Quality Improvement Program and dedicated fifteen full-time employees to continuing education and training. This staff is responsible for monitoring internal control issues and implementing processes to improve overall quality of the TennCareSM operation.

The underpayment to the hospital provider noted in the State Audit sample has been corrected.

2. Deficiencies in provider agreements

Finding

Blue Cross and Blue Shield of Tennessee 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 Blue Cross and Blue Shield of Tennessee.

Section 2-18 of the contract between TennCare and Blue Cross and Blue Shield of Tennessee specifies 36 (a through jj) items that provider agreements must meet. Among the items missing from provider agreements were:

- i. Provide that emergency services be rendered without the requirement of prior authorization of any kind;
- 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.
- 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

Blue Cross and Blue Shield of Tennessee should comply with the TennCare Bureau's requirement regarding provider agreements. The provider agreements should contain all items specified in section 2-18 of the TennCare contract.

Management's Comment

Blue Cross and Blue Shield of Tennessee (BCBST) was made aware of the Tennessee Preferred Network (TPN) contract deficiencies as a result of the July 1996 examination by the Tennessee Department of Commerce and Insurance. Based on the findings of the Department of Commerce and Insurance, BCBST initiated amendments to the TPN contracts in order to bring them into compliance with Section 2-18 of the TennCareSM contract. There was a delay in the implementation of the amendment due to TennCareSM contractual requirements for a Managed Care Organization (MCO) to obtain approval of alternative arbitration and indemnification

language from the Department of Commerce and Insurance and Bureau of TennCareSM, respectively.

SAVINGS CALCULATION AND TENTATIVE SETTLEMENT
FOR THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 1995
PREPARED BY THE DIVISION OF STATE AUDIT

Capitation amounts paid by TennCare for 1995 dates of eligibility:

Payable by TennCare in 1995	\$ 778,199,425
Adverse selection capitation for 1995	12,326,498
Retroactive capitation adjustment for 1995	<u>17,946,621</u>
Total capitation adjustment for 1995 dates of eligibility	808,472,544
Less: management fee (10%)	<u>80,847,254</u>
Available for payment of covered services (90%)	727,625,290

Payments by Blue Cross and Blue Shield of Tennessee for covered benefits:

Cash payments January 1, 1995, through June 30, 1996, for January 1 through December 31, 1995, services	\$ 768,532,964
IBNR estimate by BCBST for FYE 12/31/95	700,000
Pharmacy rebate	(8,391,072)
Medical withhold not returned - estimate at 12/31/95	<u>17,001,803</u>
Total medical expense	743,840,089
Total loss	\$ <u><u>(16,214,799)</u></u>