

**Prudential Health Care Plan, Inc.  
d/b/a Prudential Community Care**

**For the Period  
January 1, 1995, Through December 31, 1997**

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May 25, 1999

The Honorable Don Sundquist, Governor  
and

Members of the General Assembly  
State Capitol  
Nashville, Tennessee 37243

and

The Honorable Fredia Wadley, M.D., Commissioner  
Department of Health  
344 Cordell Hull  
Nashville, Tennessee 37247

Ladies and Gentlemen:

Pursuant to the agreement between the Comptroller of the Treasury and the Department of Health, the Division of State Audit performs examinations of managed care organizations participating in the Tennessee TennCare Program under Title XIX of the Social Security Act.

Submitted herewith is the report of the examination of Prudential Health Care Plan, Inc., d/b/a Prudential Community Care, for the period January 1, 1995, through December 31, 1997.

Sincerely,

John G. Morgan  
Comptroller of the Treasury

JGM/pn  
97/017

cc: Joe Keane  
Theresa Clarke-Lindsey

State of Tennessee

# Audit Highlights

Comptroller of the Treasury

Division of State Audit

TennCare Report  
**Prudential Health Care Plan, Inc.**  
**d/b/a Prudential Community Care**  
For the Period January 1, 1995, Through December 31, 1997

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## Finding

### **Deficiencies in Claims-Processing System**

Prudential Health Care Plan, Inc., should adhere to contract reporting requirements and processing-efficiency requirements for claims processing. All data elements required for individual encounter/claims data reporting should be recorded from claims submitted by providers. Claims should be paid or denied in the time required by the TennCare Program contract. An explanation of benefits should be provided to members when a copayment is required. Prudential should accumulate out-of-pocket expenses and coordinate the out-of-pocket expenses with Tennessee Behavioral Health (page 6).

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"Audit Highlights" is a summary of the report. To obtain the complete 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

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**TennCare Report**  
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**For the Period January 1, 1995, Through December 31, 1997**

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INTRODUCTION

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**PURPOSE AND AUTHORITY OF THE EXAMINATION**

The terms and conditions for authorizing the TennCare Program, as well as the contracts between the State of Tennessee and the managed care organizations (MCOs) require that examinations of the MCOs be conducted by the Tennessee Comptroller's Office. The contract between the Tennessee Department of Health and the State Comptroller's Office also contains a provision requiring the examinations.

Under their contract with the state, the MCOs have asserted that they are in compliance with stated requirements regarding their provision of services to TennCare enrollees. The purpose of our examination is to render an opinion on the MCOs' assertions that they have complied with certain financial-related requirements of their contract with the state.

**BACKGROUND**

The Tennessee Department of Health is the single state agency responsible for administering the TennCare Program and the TennCare Partners Program. On January 1, 1994, the TennCare Program began as an approved federal waiver replacing the then-existing Medicaid Program. TennCare encompasses all services other than mental health and long-term care. On July 1, 1996, the TennCare Partners Program was initiated. TennCare Partners, which functions in the same manner as the regular TennCare Program, covers mental health services. Long-term care continues to be excluded from all TennCare waivers. The state contracts with private health maintenance organizations to provide TennCare services to beneficiaries. The health maintenance organizations are referred to as managed care organizations (MCOs).

Recipients who meet Medicaid eligibility standards are enrolled in the TennCare Program and TennCare Partners Program. In addition, certain uninsured and uninsurable individuals are eligible for enrollment. Uninsured persons may be required to pay a monthly premium. The contracting MCOs provide care for TennCare enrollees for a stated monthly capitation fee. In turn, the MCOs arrange for a network of hospitals, doctors, and other health care providers to furnish health care services for persons enrolled in the plan. Essentially, the program functions much the same as a conventional health care delivery system under managed care.

Prudential Health Care Plan, Inc., is a wholly owned subsidiary of PRUCO, Inc., a wholly owned subsidiary of The Prudential Insurance Company of America. Prudential Health Care Plan,

Inc., (PHCPI) was granted a license to conduct business in Tennessee as an HMO on June 12, 1980. Prudential Community Care was developed to provide medical services under the newly established TennCare Program effective January 1, 1994. On December 31, 1995, the enrollment in the TennCare Program for PHCPI was approximately 8,900 members; December 31, 1996, approximately 9,700 members; and December 31, 1997, approximately 12,000 members.

PHCPI files quarterly and annual statements with the Tennessee Department of Commerce and Insurance. This department uses this information to determine if the plan meets the minimum requirements for statutory reserves. The statements are filed on a statutory basis of accounting, a basis that differs from generally accepted accounting principles in that “admitted” assets must be easily converted to cash to pay for outstanding claims. “Non-admitted” assets—such as furniture, equipment, and prepaid expenses—are not included in the determination of plan assets and are reduced from equity.

PHCPI’s annual statement for the year ended December 31, 1995, reported \$609,535,600 in plan assets, \$431,425,305 in liabilities, and \$178,110,295 net worth. The plan maintained a restricted deposit with a market value of \$7,211,899 as of December 31, 1995. (A separate balance sheet for TennCare operations is not required for annual statement purposes.) A separate statement of revenues, expenses, and net worth for TennCare operations for the year ended December 31, 1995, reported TennCare premium revenues of \$13,313,720, medical expenses of \$12,263,571, and administrative expenses of \$2,643,774, resulting in a net loss of \$1,593,625.

The annual statement for the year ended December 31, 1996, reported \$652,641,237 in plan assets, \$553,495,180 in liabilities, and \$99,146,057 net worth. The plan maintained a restricted deposit with a market value of \$7,389,419 as of December 31, 1996. A separate statement of revenues, expenses, and net worth for TennCare operations for the year ended December 31, 1996, reported TennCare premium revenues of \$14,944,725, medical expenses of \$11,983,819, and administrative expenses of \$2,085,026, resulting in a net income of \$875,880.

The annual statement for the year ended December 31, 1997, reported \$710,639,581 in plan assets, \$586,891,899 in liabilities, and \$123,747,682 net worth. The plan maintained a restricted deposit with a market value of \$14,419,642 as of December 31, 1997. A separate statement of revenues, expenses, and net worth for TennCare operations for the year ended December 31, 1997, reported TennCare premium revenues of \$15,992,046, medical expenses of \$12,731,345, and administrative expenses of \$2,137,943, resulting in a net income of \$1,122,758.

## **SCOPE OF THE EXAMINATION**

Our examination covers certain financial-related requirements of the contract between the state and Prudential Health Care Plan, Inc., for the period January 1, 1995, through December 31, 1997. The requirements covered are referred to under management’s assertions specified later in the Independent Accountant’s Report. Our examination does not cover those portions of the contract concerning quality of care, clinical, and medical requirements.

## **PRIOR EXAMINATION FINDING**

The previous examination of Prudential Health Care Plan, Inc., for the year ended December 31, 1994, included the following finding:

- Deficiency in Claims-Processing System—Prudential Health Care Plan, Inc., did not provide TennCare uninsured enrollees an explanation of benefits for copayments and deductibles paid.

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

## **EXAMINATION ADJUSTMENTS**

As a result of the examination, the TennCare statement of revenue and expenses for the period January 1 through December 31, 1998, was adjusted by the Division of State Audit for a cumulative underreported revenue of \$416,893 and for the corresponding premium tax expense. The adjustments consist of the following:

- Revenue should be increased by \$261,375 for the adverse selection payment by TennCare in December 1997 that was not recorded in Prudential's TennCare accounts.
- Revenue should be increased by \$112,949 for the medical technology payment by TennCare in December 1997 that was not recorded in Prudential's TennCare accounts.
- Accounts receivable should be decreased by \$36,094 for the TennCare rate increase for 1997 received in February 1998 that was overaccrued.
- Premium tax expense should be increased by \$8,338 for the 2 percent tax on the underreported revenue.

The effect of these adjustments for the TennCare operations of Prudential is to increase the net income from \$1,122,758 to \$1,531,313 as of December 31, 1997, and to increase equity by \$408,555.

## **Independent Accountant's Report**

February 26, 1999

The Honorable Don Sundquist, Governor

and

Members of the General Assembly

State Capitol

Nashville, Tennessee 37243

and

The Honorable Fredia Wadley, M.D., Commissioner

Department of Health

344 Cordell Hull

Nashville, Tennessee 37247

Ladies and Gentlemen:

We have examined management's assertions, included in its representation letter dated October 1, 1998, that Prudential Health Care Plan, Inc., complied with the following requirements during the period January 1, 1995, through December 31, 1997.

- Agreements with subcontractors and with medical providers contain the required provisions as specified in the contract with the state.
- Assets and liabilities are properly classified as "admitted" or "non-admitted" on the annual National Association of Insurance Commissioners (NAIC) report which is completed on a statutory basis of accounting and filed with the state.
- The organization is in compliance with the minimum equity requirements specified in the contract with the state.
- The organization has complied with its contractual duty to provide certain member services to its enrollees such as membership cards, provider directories, assignment of a primary care provider, and information on filing grievances.

As discussed in management's representation letter, management is responsible for ensuring compliance with those requirements. Our responsibility is to express an opinion on management's assertions about the organization's compliance based on our examination.

Our examination was made in accordance with standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence about the compliance of Prudential Health Care Plan, Inc., d/b/a Prudential Community Care, with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination on the compliance of Prudential Health Care Plan, Inc., d/b/a Prudential Community Care, with specified requirements.

Our examination disclosed the following material noncompliance applicable to Prudential Health Care Plan, Inc., d/b/a Prudential Community Care:

- The organization is not in compliance with contractual claims-processing requirements.
- The organization is not in compliance with contractual reporting requirements.

In our opinion, except for the material noncompliance described above, management's assertions that Prudential Health Care Plan, Inc., complied with the aforementioned requirements for the period January 1, 1995, through December 31, 1997, is fairly stated, in all material respects.

This report is intended solely for the use of the Tennessee General Assembly and the Tennessee Department of Health. However, this report is a matter of public record and its distribution is not limited.

Sincerely,

Arthur A. Hayes, Jr., CPA, Director  
Division of State Audit

AAH/pn

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## FINDING AND RECOMMENDATION

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### **Deficiencies in claims-processing system**

#### **Finding**

Fifty claims were selected for claims-processing testing for dates of services from January 1, 1995, through December 31, 1997. The following items were revealed:

- a. Prudential complied with the processing-efficiency requirements of the TennCare contract for claims with dates of service January 1, 1995, through December 31, 1995. The average processing lag for clean claims was 26 days from receipt of the claim to final adjudication. "Clean claims" are claims which do not require additional information from the medical provider before processing. Section 2-18 of the contract effective in 1995 states, "The Contractor agrees to make payments within thirty (30) calendar days of receipt for at least ninety-five percent (95%) of all clean claims submitted by contract providers."
- b. Our review noted two processing and payment errors in the 33 claims selected for testing for dates of service January 1, 1996, through December 31, 1997:
  1. The claim was paid based on one day of service when three days should have been paid.
  2. The correct per diem amount was paid, but all ancillary charges in addition to the per diem were also paid.
- c. Prudential was unable to provide six claims selected for testing.
- d. Prudential inadequately reported encounter data required by Attachment II, Exhibit E, of the TennCare contract. Encounter data, a record of medical service provided to enrollees, is necessary to evaluate quality of care and access to TennCare services. The following deficiencies were noted in the 33 claims selected for testing for dates of service January 1, 1996, through December 31, 1997:
  - For two claims, the diagnosis codes entered into the claims-processing system did not agree with the diagnosis codes reported on the claims.
  - For one claim, the admitting diagnosis reported on the claim was not entered into the claims-processing system.

- e. Uninsured members who are required to pay copayments are not provided an explanation of benefits (EOB). An EOB is a written communication to the TennCare member concerning any amounts the member may owe the medical provider.
- f. Prudential did not accumulate members' out-of-pocket expenses for the purpose of not exceeding the members' annual and lifetime limits.
- g. Prudential did not coordinate with Tennessee Behavioral Health for out-of-pocket limits for its participants. As a result, TennCare members could exceed their annual out-of-pocket limit because both the MCO and the behavioral health organization can charge a copayment.
- h. Prudential did not meet claims-processing requirements specified by the TennCare contract. Claims submitted by providers for medical services were not always processed within the 60-day requirement. Prudential failed to pay or deny 95% of the clean claims tested within the 30-day requirement and to pay or deny the remaining 5% (100% of all clean claims) within ten calendar days. All of the 33 claims tested for dates of service January 1, 1996, through December 31, 1997, were clean claims with the following time lags:
  - 25 claims within 30 days (76%)
  - 6 claims within the next 10 days (18%)
  - 1 claim within 41 to 60 days (3%)
  - 1 claim after 60 days (3%)

These inaccuracies and inefficiencies in the claims-processing system indicate Prudential's failure to fulfill the claims-processing requirements of the TennCare contract.

### **Recommendation**

Prudential Health Care Plan, Inc., should adhere to contract reporting requirements and claims-processing-efficiency requirements. All claims submitted should be retained by Prudential. All data elements required for individual encounter/claims data reporting should be accurately recorded from claims providers submitted. An EOB should be provided to members when a copayment is required. Prudential should accumulate out-of-pocket expenses and coordinate the out-of-pocket expenses with Tennessee Behavioral Health.

### **Management's Comment**

Please know that Prudential HealthCare is currently compliant with the TennCare requirements for the submission of encounter data to the Bureau of TennCare.

In regard to the claims processing standards, in October of 1998, Prudential HealthCare's National Service Center addressed the claims processing issue by obtaining additional staff for the

Medicaid Claims Processing Unit. Staff was dedicated to work the backlog of claims, which has resulted in Prudential HealthCare consistently meeting the thirty-day standard for processing claims. Prudential HealthCare has been compliant with this standard since November of 1998. However, on an on-going basis, the National Service Center continues to monitor claims processing activities using TennCare's claim standards.

Additionally, Prudential HealthCare has spoken with officials at the Bureau of TennCare and has written a letter requesting approval to eliminate Prudential HealthCare's copayment policies for its uninsured and uninsurable TennCare membership. Once approval has been granted, Prudential HealthCare will notify these members and reissue membership cards indicating no copayments are required.